Senate Sénat

CANADA

CANNABIS :

OUR POSITION FOR A CANADIAN PUBLIC POLICY

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

VOLUME I : PARTS I AND II

CHAIRMAN

PIERRE CLAUDE NOLIN

DEPUTY CHAIRMAN

COLIN KENNY

SEPTEMBER 2002

ORDER OF REFERENCE

Extract from the Journals of the Senate of March 15, 2001:

Resuming debate on the motion of the Honourable Senator Nolin, seconded by the Honourable Senator Molgat:

That a special committee of the Senate be struck to examine:

- The approach taken by Canada to cannabis, its preparations, derivatives and similar synthetic preparations, in context;

- The effectiveness of this approach, the means used to implement it and the monitoring of its application;

- The related official policies adopted by other countries;

- Canada's international role and obligations under United Nations agreements and conventions on narcotics, in connection with cannabis, the Universal Declaration of Human Rights and other related treaties; and

- The social and health impacts of cannabis and the possible consequences of different policies;

That the special committee consist of five senators, three of whom shall constitute a quorum;

That the Honourable Senators Banks, Kenny, Nolin, Rossiter and (a fifth Senator to be named by the Chief Government Whip) be named to the committee.

That the committee be authorized to send for persons, papers and records, to hear witnesses, to report from time to time, and to print from day to day such papers and evidence as may be ordered by it;

That the briefs and evidence heard during consideration of Bill C-8, *An Act respecting the control of certain drugs, their precursors and other substances and to amend certain other Acts and repeal the Narcotic Control Act in consequence thereof*, by the Standing Senate Committee on Legal and Constitutional Affairs during the Second Session of the Thirty-fifth Parliament be referred to the committee;

That the documents and evidence compiled on this matter and the work accomplished by the Special Senate Committee on Illegal Drugs during the Second Session of the Thirty-sixth Parliament be referred to the committee;

That the committee be empowered to authorize, if deemed appropriate, the broadcasting on radio and/or television and the coverage via electronic media of all or a part of its proceedings and the information it holds;

That the committee present its final report no later than August 31, 2002; and that the committee retain the powers necessary to publicize its findings for distribution of the study contained in its final report for 30 days after the tabling of that report;

That the committee be authorized, notwithstanding customary practice, to table its report to the Clerk of the Senate if the Senate is not sitting, and that a report so tabled be deemed to have been tabled in the Senate.

After debate,

The question then being put on the main motion as amended, it was adopted.

103-02199/

Extract from the Journals of the Senate of May 9, 2002:

The Honourable Senator Nolin moved, seconded by the Honourable Senator Stratton,

That the date of presentation by the Special Senate Committee on Illegal Drugs of the final report on its study into reassessing Canada's anti-drug legislation and policies, which was authorized by the Senate on March 15, 2001, be extended from August 31, 2002 to September 13, 2002.

The question being put on the motion, it was adopted.

ATTEST:

Paul C. Bélisle
Clerk of the Senate

A Word of Thanks

I am very proud of the report on cannabis being made public today by the Senate Special Committee on Illegal Drugs. It marks a stage in Canada's public policy on drugs, and I have no doubt that it will find an attentive readership, despite its impressive size.

The report is the product of a team effort over a period of two years. At the risk of leaving anyone out, and I hope I will be pardoned should I do so, I would like to express my gratitude to those most closely involved with the project.

I would first thank all Canadians, who, from near and far, shared in our efforts, by writing us, by attending our hearings and our open forums in the regions, by watching us on television and, quite simply, by taking the time to learn about this important social policy issue. Their contributions, their questions and their comments were a source of inspiration. We will not forget the welcome given us by the Chiefs of the Piapot tribe in Saskatchewan. The ceremony they held for us was truly healing.

The Committee could not have done its work without the immense contribution of its research team. This small group was under the able direction of sociologist Dr Daniel Sansfaçon, whose rigour and devotion enabled the Committee to meet the highest standards of quality in its work and in the drafting of its report. Mr Gérald Lafrenière and Ms Chantal Collin, researchers with the Parliamentary Research Branch of the Library of Parliament working with him, provided invaluable support. I would take the opportunity to thank the Parliamentary Research Branch and its Director General specifically for their diligence and professionalism in responding to our imposing program of work. Finally, I wish to mention the contributions by Ms Barbara Buston Wheelok, assistant to Senator Rossiter, to Mr François Dubois, my research assistant, and to Messrs Jean-Guy Desgagné and David Newman in Communications.

The Committee benefited in its work from the expertise and the generosity of the many experts who testified before it or whom it met privately, and whose names are appended. I would thank them one and all.

We were also able to draw on the competence of the committee clerks and on the efficiency of their administrative personnel in organizing our many working and public meetings. My thanks to Blair Armitage, Daniel Charbonneau and Adam Thompson.

Our report, with its great concern for transparency and rigour, exemplifies the highest standards maintained by the Senate. I would thank my colleagues in the Senate, who entrusted us with this mandate. In concluding, I would like to express my gratitude to my colleagues who took part in our work and especially to each of the members of the Senate Special Committee on Illegal Drugs: its Deputy Chair, Senator Colin Kenny, and Senators Tommy Banks, Shirley Maheu and Eileen Rossiter. They did a remarkable job.

My colleagues, I believe Canadians may rightly be proud of our parliamentary institution.

Pierre Claude Nolin
Senator
Chair, Senate Special Committee on Illegal Drugs

MEMBERS OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

1. MEMBERS OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

Honourable Pierre Claude Nolin
(Chair)

Honourable Colin Kenny
(Deputy Chair)

Honourable Tommy Banks

Honourable Eileen Rossiter

Honourable Shirley Maheu

Honourable John Lynch-Staunton *

Honourable Sharon Carstairs, P.C.* **

Honourable Noël A. Kinsella *

Honourable Fernand Robichaud, P.C. *

2. OTHER SENATORS WHO PARTICIPATED IN THE PROCEEDINGS OF THE COMMITTEE

Honourable Michel Biron

Honourable Laurier LaPierre

Honourable Pat Carney, P.C.

Honourable Jean Lapointe

Honourable Thelma Chalifoux

Honourable Edward M. Lawson

Honourable Ione Christensen

Honourable Lorna Milne

Honourable Ethel M. Cochrane

Honourable Yves Morin

Honourable Pierre De Bané, P.C., Q.C.

Honourable Lucie Pépin ***

Honourable Consiglio Di Nino

Honourable Marie-P. Poulin

Honourable Joyce Fairbairn, P.C.

Honourable Marcel Prud'homme, P.C.

Honourable Sheila Finestone, P.C.

Honourable Gerry St. Germain, P.C.

Honourable J. Michael Forrestall

Honourable Peter A. Stollery

Honourable Jerahmiel S. Grafstein, Q.C.

Honourable Terry Stratton

Honourable Mobina S.B. Jaffer

Honourable John Wiebe

Honourable Lois M. Wilson

* *Ex Officio* Members
** The Honourable Sharon Carstairs was a member of the Committee from April 2000 to October 2000
*** The Honourable Lucie Pépin was a member of the Committee from April 2000 to October 2000

TABLE OF CONTENTS

INTRODUCTION 1

PART I - GENERAL ORIENTATION 5

CHAPTER 1 - OUR MANDATE 7
WORDING 7
ORIGINS 9
INTERPRETATION 10

CHAPTER 2 - OUR WORK 13
TWO WORKING PRINCIPLES 14
STATE OF KNOWLEDGE 15
Research Program 18
Expert Witnesses 19
The Challenge of Synthesis 21
TAKING OPINIONS INTO ACCOUNT 22
INTERPRETING IN LIGHT OF PRINCIPLES 23

CHAPTER 3 - OUR GUIDING PRINCIPLES 25
ETHICS, OR THE PRINCIPLE OF RECIPROCAL AUTONOMY 28
GOVERNANCE: MAXIMIZING THE ACTIONS OF INDIVIDUALS 32
Collective governance 34
Governance of the self 35
The role of governance 37
CRIMINAL LAW AND THE LIMITS OF PROHIBITION 38
Requirement for distinctions 38
Criteria for distinction 40
Application to illegal drugs issues 44
SCIENCE OR APPROXIMATE KNOWLEDGE 45
CONCLUSIONS 49

CHAPTER 4 - A CHANGING CONTEXT 51
CHANGES IN THE INTERNATIONAL SPHERE 51
Globalization and Integration 51
Difficulties of the Security Debate 55
From Anti-Drug Policies to Drug Policies 57
CHANGES IN CANADA 58
Judicial Activism 58
A National Crime Prevention Strategy 59
The Fight Against Organized Crime 59
A SOCIETAL DEBATE 60

PART II - CANNABIS: EFFECTS, TYPES OF USE, ATTITUDES 63

CHAPTER 5 - CANNABIS : FROM PLANT TO JOINT 65
ONE PLANT, VARIOUS DRUGS 66
CANNABIS ROADS 69
PROPERTIES OF CANNABIS 77
Δ^9THC Concentrations 78
Pharmacokinetics 83
CONCLUSIONS 87

CHAPTER 6 - USERS AND USES : FORM, PRACTICE, CONTEXT 89
PATTERNS OF USE 90
Consumption by the population as a whole 91
Consumption among young people 94
Use patterns in other countries 101
To summarize 108
PATTERNS AND CIRCUMSTANCES OF USE 111
Cannabis in History 111
Trajectories of Use 113
Factors Related to Use 119
To summarize 124
STEPPING STONE TOWARDS OTHER DRUGS? 125
CANNABIS, VIOLENCE AND CRIME 127
CONCLUSIONS 128

CHAPTER 7 - CANNABIS : EFFECTS AND CONSEQUENCES 131
EFFECTS AND CONSEQUENCES OF CANNABIS: WHAT WE WERE TOLD 134
ACUTE EFFECTS OF CANNABIS 139
CONSEQUENCES OF CHRONIC USE 143
Physiological Consequences of Chronic Use 143
Cognitive and Psychological Consequences 148
Behavioural and Social Consequences 152
TOLERANCE AND DEPENDENCE 152
Cannabis Dependence 154
Severity of Dependence 160
Tolerance 162
To summarize 163
CONCLUSIONS 164

CHAPTER 8 - DRIVING UNDER THE INFLUENCE OF CANNABIS 167
FORMS OF TESTING 170
EPIDEMIOLOGICAL DATA 175
Studies not involving accidents 175
Studies where an accident was involved 176
Epidemiological studies on youth 179

Risk assessment 180
EXPERIMENTAL STUDIES 182
Non-driving activities 183
While driving 184
CONCLUSIONS 188

CHAPTER 9 - USE OF MARIJUANA FOR THERAPEUTIC PURPOSES 191
HISTORY 196
CONTEMPORARY KNOWLEDGE 197
Therapeutic uses 198
Marijuana as a drug? 200
CURRENT THERAPEUTIC PRACTICES 203
CONCLUSIONS 205

CHAPTER 10 - CANADIANS' OPINIONS AND ATTITUDES 209
THE MEDIA 210
SURVEYS 215
ATTITUDES AND OPINIONS SHARED WITH THE COMMITTEE 221
CONCLUSIONS 224

PART III - POLICIES AND PRACTICES IN CANADA 225

CHAPTER 11 - A NATIONAL DRUG STRATEGY? 227
PHASE I - DEVELOPMENT AND IMPLEMENTATION 228
Creation of the Canadian Centre on Substance Abuse 233
Creation of Canada's Drug Strategy Secretariat 236
PHASE II - RENEWAL 237
PHASE III – RENEWAL WITHOUT SPECIFIED FUNDING 240
CANADA'S DRUG STRATEGY – A SUCCESS? 241
CONCLUSIONS 243

CHAPTER 12 - THE NATIONAL LEGISLATIVE CONTEXT 245
1908-1960: HYSTERIA 248
Opium Act, 1908 252
The Opium and Narcotic Drug Act, 1911 253
Amendments to the Opium and Narcotic Drug Act (1920-1938) 255
Amendments to the Act to Amend the Opium and Narcotic Drug Act in 1954 263
Senate Report of 1955 264
FROM 1960 TO THE LE DAIN COMMISSION: THE SEARCH FOR REASONS 268
Narcotic Control Act (1961) 268
An Act respecting Food and Drugs and Barbiturates (1961) 270
The Le Dain Commission (1969-1973) 272
Bill S-19 and Cannabis 283
AFTER LE DAIN: FORGING AHEAD REGARDLESS 284
Controlled Drugs and Substances Act 286
CONCLUSIONS 295

CHAPTER 13 - REGULATING THERAPEUTIC USE OF CANNABIS **297**
BACKGROUND TO THE RECENT REGULATIONS 298
Section 56 – Controlled Drugs and Substances Act 298
Charter Challenges – Therapeutic Use of Marijuana 299
Government Reaction 302
MARIHUANA MEDICAL ACCESS REGULATIONS 302
Authorization to Possess 303
Licence to Produce 306
Other Provisions 307
COMPASSIONATE ACCESS? 308
Eligibility 309
Access to cannabis 312
Products 316
Costs 316
RESEARCH PLAN 317
Scientific Research 318
Research-Grade Marijuana 320
CONCLUSIONS 321

CHAPTER 14 - POLICE PRACTICES **323**
ENFORCEMENT AGENCIES 323
RCMP 323
CHARGES UNDER THE CONTROLLED DRUGS AND SUBSTANCES ACT IN 1999 326
TheCanada Customs and Revenue Agency 326
Provincial and Municipal Police 328
COSTS 328
POLICE POWERS 333
Searches and Seizures 335
Entrapment and Illegal Activity 347
Conclusion 352
STATISTICS 353
Reported Incidents 353
Charges 356
Concerns 359
Customs Act - Fines 361
SEIZURES 362
CONCLUSIONS 364

CHAPTER 15 - THE CRIMINAL JUSTICE SYSTEM **367**
PROSECUTION 367
COURTS 368
Drug Treatment Courts 369
DISPOSITION AND SENTENCING 372
CORRECTIONS 376
CRIMINAL RECORD 379
COURT CHALLENGES 382
CONCLUSIONS 387

CHAPTER 16 - PREVENTION **389**
INITIATIVES THAT FALL SHORT OF THE MARK 393
Not enough prevention 394
Prevention lacks focus 396
There is not enough evaluation of preventive measures 397
Preventive and social messages in contradiction 398
There is a body of knowledge on which we have to draw 399
PREVENTING WHAT AND HOW? 400
RISK REDUCTION AND HARM REDUCTION 410
CONCLUSIONS 412

CHAPTER 17 - TREATMENT PRACTICES **415**
CANNABIS DEPENDENCY 415
FORMS OF TREATMENT 421
EFFECTIVENESS OF TREATMENT 423
CONCLUSIONS 426

CHAPTER 18 - OBSERVATIONS ON PRACTICES **427**
DIFFICULTIES IN HARMONIZING THE PLAYERS 427
INCONGRUITIES OF APPROACH 429
SIGNIFICANT ECONOMIC AND SOCIAL COSTS 431

PART IV - PUBLIC POLICY OPTIONS **437**

CHAPTER 19 - THE INTERNATIONAL LEGAL ENVIRONMENT **439**
A GENEALOGY 440
The 1909 Shanghai Conference 443
The 1912 Hague International Opium Convention 444
The 1925 Geneva Opium Conventions 446
The 1931 Geneva Narcotics Manufacturing and Distribution Limitation Convention / 1931 Bangkok Opium Smoking Agreement 447
The 1936 Geneva Convention for the Suppression of the Illicit Traffic in Dangerous Drugs 448
The Second World War 449
The 1946 Lake Success Protocol 449
The 1948 Paris Protocol 450
The 1953 New York Opium Protocol 450
THE THREE CURRENT CONVENTIONS 451
The Single Convention on Narcotic Drugs, 1961 451
Convention on Psychotropic Substances 455
Protocol amending the Single Convention on Narcotic Drugs, 1961 460
Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 462
SOME LEEWAY? 464
CONCLUSIONS 468

CHAPTER 20 - PUBLIC POLICIES IN OTHER COUNTRIES	**469**
FRANCE	470
Different Forms of Logic	470
An Integrated Public Policy	472
Legislative Framework	474
Key Reports	477
Statistics on Use and Offences	481
Costs	483
THE NETHERLANDS	485
Dutch Pragmatism?	486
Essential Experts Reports	488
Legislation	493
The Coffee Shop System	496
Data on Use	498
UNITED KINGDOM	502
Ten-Year Strategy to Battle Drugs	502
Legislative Framework	503
Other Relevant Legislation in the Field of Drug Misuse	505
Debate in the UK	506
Recent Key Reports and Studies	507
Administration	515
Costs	515
Statistics	516
SWEDEN	518
National Strategy	520
Legislative Framework	523
Debate in Sweden	525
Recent Reports	526
Costs	528
Administration	528
Statistics	529
SWITZERLAND	531
A Harm Reduction Policy	531
The Legal Framework	538
A Bill to Decriminalize Cannabis	539
Administration of Swiss Drug Policy	542
Statistics on Narcotics Use and Offences under the Narcotics Act	544
AUSTRALIA	546
National Drug Strategy	546
Legislative Framework	551
Decriminilization in Australia	554
Administration	556
Statistics	557
UNITED STATES	560
The Federal-State Legislative Framework	560
Current Legislation and Enforcement	563
Federal Drug Policy Goals and Objectives	570
Administration of the Policy	572
Current Issues and Debates	575

Statistics 576

CHAPTER 21 - PUBLIC POLICY OPTIONS **581**
INEFFECTIVENESS OF CRIMINAL POLICIES 583
Impact on Consumption 583
Impact on Supply 589
Conclusion 590
GENERAL ECONOMY OF A PUBLIC POLICY ON CANNABIS 591
COMPONENTS OF A PUBLIC POLICY 593
Strong Decision-making Body 593
Interconnection 594
A Shared Definition of Shared Objectives 594
Information Tools 594
LEGISLATIVE OPTIONS 595
Clarification of criminology 595
Criteria for a Legal Policy on Cannabis 602

CONCLUSIONS AND RECOMMENDATIONS **607**

LE DAIN – ALREADY THIRTY YEARS AGO 607
INEFFECTIVENESS OF THE CURRENT APPROACH 609
PUBLIC POLICY BASED ON GUIDING PRINCIPLES 610
A CLEAR AND COHERENT FEDERAL STRATEGY 611
NATIONAL STRATEGY SUSTAINED BY ADEQUATE RESOURCES AND TOOLS 612
A PUBLIC HEALTH POLICY 614
A REGULATORY APPROACH TO CANNABIS 617
A COMPASSION-BASED APPROACH FOR THERAPEUTIC USE 618
PROVISIONS FOR OPERATING A VEHICLE UNDER THE INFLUENCE OF CANNABIS 619
RESEARCH 620
CANADA'S INTERNATIONAL POSITION 621

PROPOSALS FOR IMPLEMENTING THE REGULATION OF CANNABIS FOR THERAPEUTIC AND RECREATIONAL PURPOSES **623**

BIBLIOGRAPHY **627**

GLOSSARY OF KEY TERMS

Abuse
Vague term with a variety of meanings depending on the social, medical and legal contexts. Some equate any use of illicit drugs to abuse: for example, the international conventions consider that any use of drugs other than for medical or scientific purposes is abuse. The Diagnosis and Statistical Manual of the American Psychiatric Association defines abuse as a maladaptive pattern of substance use leading to clinically significant impairment or distress as defined by one or more of four criteria (see chapter 7). In the report, we prefer the term excessive use (or harmful use).

Acute effects
Refers to effects resulting from the administration of any drug and specifically to its short term effects. These effects are distinguished between central (cerebral functions) and peripheral (nervous system). Effects are dose-related.

Addiction
General term referring to the concepts of tolerance and dependency. According to WHO addiction is the repeated use of a psychoactive substance to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance, has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain the substance by almost any means. Some authors prefer the term addiction to dependence, because the former also refers to the evolutive process preceding dependence.

Agonist
A substance that acts on receptor sites to produce certain responses.

Anandamide
Agonist neurotransmitter of the endogenous cannabinoid system. Although not yet fully understood in research, these neurotransmitters seem to act as modulators, THC increasing the liberation of dopamine in nucleus accumbens and cerebral cortex.

At-risk use
Use behaviour which makes users at-risk of developing dependence to the substance.

Cannabinoids
Endogenous receptors of the active cannabis molecules, particularly 9-THC. Two endogenous receptors have been identified: CB1 densely concentrated in the hippacampus, basal ganglia, cerebellum and cerebral cortex, and CB2, particularly abundant in the immune system. The central effects of cannabis appear to be related only to CB1.

Cannabis
Three varieties of the cannabis plant exist: *cannabis sativa*, *cannabis indica*, and *cannabis ruredalis. Cannabis sativa* is the most commonly found, growing in almost any soil condition. The cannabis plant has been known in China for about 6000 years. The flowering tops and leaves are used to produce the smoked cannabis. Common terms used to refer to cannabis are pot, marihuana, dope, ganja, hemp. Hashish is produced from the extracted resin. Classified as a psychotropic drug, cannabis is a modulator of the central nervous system. It contains over 460 known

chemicals, of which 60 are cannabinoids. Delta-9-tétrahydrocannabinol, referred to as THC, is the principal active ingredient of cannabis. Other components such delta-8-tétrahydrocannabinol, cannabinol and cannabidiol are present in smaller quantities and have no significant impacts on behaviour or perception. However, they may modulate the overall effects of the substance.

Chronic effects
Refers to effects which are delayed or develop after repeated use. In the report we prefer to use the term consequences of repeated use rather than chronic effects.

Commission on narcotic drugs (CND)
The Commission on Narcotic Drugs (CND) was established in 1946 by the Economic and Social Council of the United Nations. It is the central policy-making body within the UN system for dealing with all drug-related matters. The Commission analyses the world drug abuse situation and develops proposals to strengthen international drug control.

Decriminalization
Removal of a behaviour or activity from the scope of the criminal justice system. A distinction is usually made between *de jure decriminalization*, which entails an amendment to criminal legislation, and *de facto decriminalization*, which involves an administrative decision not to prosecute acts that nonetheless remain against the law. Decriminalization concerns only criminal legislation, and does not mean that the legal system has no further jurisdiction of any kind in this regard: other, non-criminal, laws may regulate the behaviour or activity that has been decriminalized (civil or regulatory offences, etc.).

Diversion
The use of measures other than prosecution or a criminal conviction for an act that nonetheless remains against the law. Diversion can take place before a charge is formally laid, for example if the accused person agrees to undergo treatment. It can also occur at the time of sentencing, when community service or treatment may be imposed rather than incarceration.

Depenalisation
Modification of the sentences provided in criminal legislation for a particular behaviour In the case of cannabis, it generally refers to the removal of custodial sentences.

Dependence
State where the user continues its use of the substance despite significant health, psychological, relational, familial or social problems. Dependence is a complex phenomenon which may have genetic components. Psychological dependence refers to the psychological symptoms associated with craving and physical dependence to tolerance and the adaptation of the organism to chronic use. The American Psychiatric Association has proposed seven criteria (see chapter 7).

Dopamine
Neuromediator involved in the mechanisms of pleasure.

Drug
Generally used to refer to illicit rather than licit substances (such as nicotine, alcohol or medicines). In pharmacology, the term refers to any chemical agent that alters the biochemical or physiological processes of tissues or organisms. In this sense, the term drug refers better to any substance which is principally used for its psychoactive effects.

European Monitoring Centre on Drugs and Drug Addiction (EMCDDA)
The European Monitoring Centre was created in 1993 to provide member states objective, reliable and comparable information within the EU on drugs, drug addictions and their consequences. Statistical information, documents and techniques developed in the EMCDDA are designed to give a broad perspective on drug issues in Europe. The Centre only deals with information. It relies on national focal points in each of the Member States.

Fat soluble
Characteristic of a substance to irrigate quickly the tissues. THC is highly fat-soluble.

Gateway (theory)
Theory suggesting a sequential pattern in involvement in drug use from nicotine to alcohol, to cannabis and then "hard" drugs. The theory rests on a statistical association between the use of hard drugs and the fact that these users have generally used cannabis as their first illicit drug. This theory has not been validated by empirical research and is considered outdated.

Half-life
Time needed for the concentration of a particular drug in blood to decline to half its maximum level. The half-life of THC is 4.3 days on average but is faster in regular than in occasional users. Because it is highly fat soluble, THC is stored in fatty tissues, thus increasing its half life to as much as 7 to 12 days. Prolonged use of cannabis increases the period of time needed to eliminate is from the system. Even one week after use, THC metabolites may remain in the system. They are gradually metabolised in the urine (one third) and in feces (two thirds). Traces on inactive THC metabolites can be detected as many as 30 days after use.

Hashish
Resinous extract from the flowering tops of the cannabis plant and transformed into a paste.

International Conventions
Various international conventions have been adopted by the international community since 1912, first under the Society of Nations and then under the United Nations, to regulate the possession, use, production, distribution, sale, etc., of various psychotropic substances. Currently, the three main conventions are the 1961 Single Convention, the 1971 Convention on Psychotropic Substance and the 1988 Convention against Illicit Traffic. Canada is a signatory to all three conventions. Subject to countries' national constitutions, these conventions establish a system of regulation where only medical and scientific uses are permitted. This system is based on the prohibition of source plants (coca, opium and cannabis) and the regulation of synthetic chemicals produced by pharmaceutical companies.

International Narcotics Control Board (INCB)
The Board is an independent, quasi-judicial organisation responsible for monitoring the implementation of the UN conventions on drugs. It was created in 1968 as a follow up to the 1961 Single Convention, but had predecessors as early as the 1930s. The Board makes recommendations to the UN Commission on Narcotics with respect to additions or deletions in the appendices of the conventions.

Intoxication
Disturbance of the physiological and psychological systems resulting from a substance. Pharmacology generally distinguishes four levels: light, moderate, serious and fatal.

Joint
Cigarette of marijuana or hashish with or without tobacco. Because joints are never identical, scientific analyses of the effects of THC are more difficult, especially in trying to determine the therapeutic benefits of cannabis and to examine its effects on driving.

Legalisation
Regulatory system allowing the culture, production, marketing, sale and use of substances. Although none currently exist in relation to «street-drugs» (as opposed to alcohol or tobacco which are regulated products), a legalisation system could take two forms: without any state control (free markets) and with state controls (regulatory regime).

Marijuana
Mexican term originally referring to a cigarette of poor quality. Has now become equivalent for cannabis.

Narcotic
Substance which can induce stupor or artificial sleep. Usually restricted to designate opiates. Sometimes used incorrectly to refer to all drugs capable of inducing dependence.

Office of national drug control policy (ONDCP) USA
Created in 1984 under the Reagan presidency, the Office is under the direct authority of the White House. It coordinates US policy on drugs. Its budget is currently US $18 billion.

Opiates
Substance derived from the opium poppy. The term opiate excludes synthetic opioids such as heroin and methadone.

Prohibition
Historically, the term designates the period of national interdiction of alcohol sales in the United States between 1919 and 1933. By analogy, the term is now used to describe UN and State policies aiming for a drug-free society. Prohibition is based on the interdiction to cultivate, produce, fabricate, sell, possess, use, etc., some substances except for medical and scientific purposes.

Psychoactive substance
Substance which alters mental processes such as thinking or emotions. More neutral than the term "drug" because it does not refer to the legal status of the substance, it is the term we prefer to use.

Psychotropic substance (see also psychoactive)
Much the same as psychoactive substance. More specifically however, the term refers to drugs primarily used in the treatment of mental disorders, such as anxiolytic, sedatives, neuroleptics, etc. More specifically, refers to the substances covered in the 1971 Convention on Psychotropic Substances.

Regulation
Control system specifying the conditions under which the cultivation, production, marketing, prescription, sales, possession or use of a substance are allowed. Regulatory approaches may rest on interdiction (as for illegal drugs) or controlled access (as for medical drugs or alcohol). Our proposal of an exemption regime under the current legislation is a regulatory regime.

Society of Nations (SDN)
International organisation of States until 1938; now the United Nations.

Tetrahydrocannabinol (Δ9-THC)
Main active component of cannabis, Δ9-THC is very fat-soluble and has a lengthy half-life. Its psychoactive effects are modulated by other active components in cannabis. In its natural state, cannabis contains between 0.5% to 5% THC. Sophisticated cultivation methods and plant selection, especially female plants, leads to higher levels of THC concentration.

Tolerance
Reduced response of the organisms and increased capacity to support its effects after a more or less lengthy period of use. Tolerance levels are extremely variable between substances, and tolerance to cannabis is believed to be lower than for most other drugs, including tobacco and alcohol.

Toxicity
Characteristic of a substance which induces intoxication, i.e., "poisoning". Many substances, including some common foods, have some level of toxicity. Cannabis presents almost no toxicity and cannot lead to an overdose.

United Nations Drug Control Program (UNDCP)
Established in 1991, the Programme works to educate the world about the dangers of drug abuse. The Programme aims to strengthen international action against drug production, trafficking and drug-related crime through alternative development projects, crop monitoring and anti-money laundering programmes. UNDCP also provides accurate statistics through the Global Assessment Programme (GAP) and helps to draft legislation and train judicial officials as part of its Legal Assistance Programme. UNDCP is part of the UN Office for Drug Control and the Prevention of Crime.

World Health Organization (WHO)
The World Health Organization, the United Nations specialized agency for health, was established on 7 April 1948. WHO's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health. Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

INTRODUCTION

The question of illegal drugs is one of the societal issues that can readily become a moral and indeed emotional matter. Who among us does not have an opinion on drugs and "drug addicts"? Who does not have a parent, friend, young cousin or uncle who has had personal problems at school or at work, perhaps even run-ins with the police and the criminal justice system, as a result of using drugs? Who has not heard of drug traffickers, veritable anti-heroes, whom we find both repulsive and fascinating, all of whom we consider the worst kind of scum, who grow rich by selling adulterated and dangerous products to our children? Every day brings its share of newspaper articles and television news reports on anti-drug operations conducted by police forces: sometimes massive, and almost always spectacular arrests, huge seizures of drugs, cash and weapons of all kinds. Every day we also see articles on money laundering and the corruption of honest men through the illegal drug market. Even closer to home, the events of September 11 shed new light on the ambiguous and alleged relations between the drug trafficking world and the financing of "terrorist" networks. Security is now the key buzz word.

The drug issue involves the political values of life in society. In what kind of society do we want to live? What place should, and can, drugs occupy in it? For some, drugs are substances that keep individuals in a state of dependence. Using them weakens their moral fibre, makes them more malleable, more subject in particular to (bad) outside influences, and reduces their ability to be productive individuals in society. If they don't bring about human downfall, drugs do prevent the full achievement and realization of human potential. For others, drugs are tools to achieving greater productivity, being more competitive and thus better positioned in a hyper-competitive world. The obvious example of this is doping among elite athletes. For still others, drugs are a preferred means of entering into contact with other aspects of their being, spiritual, artistic aspects, or simply peace and serenity. The history of art is full of examples. These almost diametrically opposed conceptions often leave little room for dialogue and result in considerable prejudice on all sides.

In the past 20 years, we have introduced stringent anti-tobacco programs. And we have definitely achieved a measure of success. We have also adopted stricter measures to put a stop to impaired driving. Here too, we believe we have made significant inroads. The fight against drugs is a kind of metaphor for the type of social policies we expect of governments: policies based on the improved well-being of citizens.

Of course, everything depends on what each person means by the word "drugs". The term is clearly not neutral: it elicits varying degrees of fear and anxiety. And we do not necessarily all include the same substances under that heading. The examples cited above concern illegal drugs, alcohol, tobacco and performance-enhancing substances. A number of psychotropic drugs could also be included. And yet, when we think of drugs, the first things that come to mind are illegal substances: cocaine and heroin, of course, crack and amphetamines for the more sophisticated among us, and, obviously, cannabis and hashish. However, an increasing number of scientific studies and government policies strive to show the interrelationships between different drugs, discussing at-risk behaviours in relation to each drug. As will be seen below, the mere fact of considering alcohol as one drug among others signifies a genuine cultural revolution in a country such as France, a major producer and consumer of wine. And tobacco companies would certainly object to comparing nicotine to heroine.

The members of the **Senate Special Committee on Illegal Drugs** addressed the question of drugs as everyone else does, that is to say with the same preconceptions, with the same basic attitudes, the same fears and the same anxieties. Of course, we had at our disposal the study which a number of our colleagues had conducted in 1996 on government legislation dealing with illegal drugs, which had enabled them to hear a number of witnesses over several months. We also knew at the outset that research expertise would be available to us, but let there be no mistake, it is nevertheless difficult to go beyond attitudes and opinions that have long been taken for granted. Whether one is in favour of enhanced enforcement or, on the contrary, greater liberalization, opinions tend to resist the facts, particularly since, in a field such as this, the production of facts, even through scientific research, is not necessarily a neutral enterprise. It follows then that we too, like you, have our prejudices and preconceptions. And together we must make the effort to go beyond them. That is one of the objectives of this report.

Our report is divided into four parts. Part I outlines our general orientations and comprises four chapters. Chapter 1 describes the Committee's origins and mandate, while Chapter 2 outlines the work we have undertaken, explaining certain choices we have made. Chapter 3 is central to the entire architecture of the report and, as it were, provides a "reading grid". In it, we state what we have called the **guiding principles** for a public policy on illegal drugs. Lastly, Chapter 4 offers a broad overview of the present situation with regard to illegal drugs, placing our efforts in the context of the changes that are occurring in various countries and on the international scene more generally.

Part II is the heart of our report. It provides a comprehensive outline of scientific research findings and the opinions of the experts we heard. Chapter 5 describes the plant from which smokable cannabis and hashish are derived and the pharmacological properties of the cannabinoids, which are their active ingredient. It also provides some figures on sources of production of cannabis and its main trafficking routes. Chapter 6 contains information on uses and users: who uses cannabis, in what circumstances,

what do we know about their user trajectories and, in particular, the highly controversial question as to whether cannabis use leads to the use of other drugs. Chapter 7 describes the physiological and psychological effects and consequences of cannabis, focusing as well on the important issues of cannabis dependence and tolerance. Chapter 8 deals specifically with the important issue of driving under the influence of cannabis. Given the current debates on the issue of therapeutic uses of cannabis, Chapter 9 reviews existing findings. Chapter 10, the last chapter in the section, addresses public opinion, outlining public opinion polls and surveys, reporting also what we were told in the consultations we held in the regions following the publication of our discussion paper in May 2002.

Part III concerns public policy and practices in Canada. When we think of drugs, we immediately think of the legislation governing them. In so doing, we forget that the law is never more than one of a number of elements involved in a public policy. Chapter 11 focuses on the National Drug Strategy, which was in effect in Canada between 1987 and 1997. It must be considered since only in this period in the history of our public drug policies was an attempt made to adopt a comprehensive and integrated strategy. Chapter 12 then describes the history of Canadian drug legislation. Chapter 13 examines the current regulatory regime for therapeutic uses of cannabis. The following four chapters deal with the various components of the implementation of the public policies on illegal drugs. Chapters 14 and 15 discuss respectively police practices and legal practices central to the implementation of those statutory provisions, while Chapters 16 and 17 briefly examine prevention practices and health care practices. Finally, in Chapter 18, we conclude this third part of our report with a series of three observations on these practices, examining in particular the economic costs and unexpected consequences of current public policies.

Part IV addresses public policy options. When it comes to drugs, we cannot avoid the architecture of the international conventions that have governed these substances since 1912. This is the subject of Chapter 19. However, beyond this global framework, countries have chosen different approaches to respond to drug related issues and problems. Chapter 20 describes in detail the public policy frameworks in seven industrialized countries. Finally, chapter 21 is key to understanding our recommendations and their links with our guiding principles. This chapter shows that the criminal law is but one of the tools of public policy in this field. It then distinguishes between the various legal options and clarifies heavily loaded terms such as decriminalisation and legalisation. Finally, based on the accumulated knowledge, our reading of public opinion and our principles, this chapter explains our framework for a comprehensive public policy on cannabis.

Based on all this knowledge gathered, we state a certain number of conclusions and offer our recommendations, which express the fundamental premise underlying our report: ***in a free and democratic society, which recognizes fundamentally but not exclusively the rule of law as the source of normative rules and in which government must promote autonomy insofar as possible and therefore make***

only sparing use of the instruments of constraint, public policy on psychoactive substances must be structured around guiding principles respecting the life, health, security and rights and freedoms of individuals, who, naturally and legitimately, seek their own well-being and development and can recognize the presence, difference and equivalence of others.

We are aware, as much now as we were at the start of our work, that there is no pre-established consensus in Canadian society on public policy choices in the area of drugs. In fact, as we have seen, there are few societies where there is a broadly shared consensus among the general public and between the public and experts. We are also aware, perhaps more so than at the outset, that the question of illegal drugs, viewed from the standpoint of the public policies that govern them, is part of a broader international context and that we cannot think or act in isolation. We are aware that our proposals are provocative, that they may meet with some resistance. However, we are convinced that Canadian society has the maturity and openness to welcome this informed debate.

In this, as in so many other areas of public policy, we say that action must be taken and that the knowledge accumulated fully supports the orientations we propose, but that first and foremost the sharing of knowledge and public debate are both necessary and desirable in the democratic life in our society.

PART I

GENERAL ORIENTATION

CHAPTER 1

OUR MANDATE

WORDING

On April 16, 2000, pursuant to a motion by Senator Pierre Claude Nolin, the Senate adopted the following order of reference:

> *That a Special Committee of the Senate be appointed to reassess Canada's anti-drug legislation and policies, to carry out a broad consultation of the Canadian public to determine the specific needs of various regions of the country, where social problems associated with the trafficking and use of illegal drugs are more in evidence, to develop proposals to disseminate information about Canada's anti-drug policy and, finally, to make recommendations for an anti-drug strategy developed by and for Canadians under which all levels of government work closely together to reduce the harm associated with the use of illegal drugs;*
>
> *That, without being limited in its mandate by the following, the committee be authorized to:*
>
> - *Review the federal government's policy on illegal drugs in Canada, its effectiveness, and the extent to which it is fairly enforced;*
> - *Develop a national harm reduction policy in order to lessen the negative impact of illegal drugs in Canada, and make recommendations regarding the enforcement of this policy,* **specifically the possibility of focusing on use and abuse of drugs as a social and health problem;**[1]
> - *Study harm reduction models adopted by other countries and determine if there is a need to implement them wholly or partially in Canada;*
> - *Examine Canada's international role and obligations under United Nations conventions on narcotics and the Universal Declaration of Human Rights and other related treaties in order to determine whether these treaties authorize it to take action other than laying criminal charges and imposing sentences at the international level;*
> - *Explore the effects of cannabis on health and examine whether alternative policy on cannabis would lead to increased harm in the short and long term;*

[1] Emphasis in the original.

- *Examine the possibility of the government using its regulatory power under the Contraventions Act as an additional means of implementing a harm reduction policy, as is done in other jurisdictions;*
- *Examine any other issue respecting Canada's anti-drug policy that the committee considers appropriate to the completion of its mandate.*

Upon adoption of the motion, the Committee chairman asked the Senate to name the members who would form the Committee. The following senators were thus appointed: Pierre Claude Nolin, Chair, Sharon Carstairs, Deputy Chair, Colin Kenny, Lucie Pépin and Eileen Rossiter.

The Committee thus constituted approved a work program and a budget, which it then submitted to its peers in the upper Chamber. The Committee's budget was approved in June 2000, thus making it possible to hire the scientific and administrative personnel who would support its work. The Committee organized its program of hearings of expert witnesses and held its first hearings on October 16, 2000.

However, the Committee was dissolved when the general election was called in October 2000, and restruck on March 15, 2001, but with an amended mandate: the scope of its work was now restricted to cannabis. The Committee's mandate in its present form therefore reads as follows:

That a special committee of the Senate be struck to examine:

- *The approach taken by Canada to cannabis, its preparations, derivatives and similar synthetic preparations, in context;*
- *The effectiveness of this approach, the means used to implement it and the monitoring of its application;*
- *The related official policies adopted by other countries;*
- *Canada's international role and obligations under United Nations agreements and conventions on narcotics, in connection with cannabis, the Universal Declaration of Human Rights and other related treaties; and*
- *The social and health impacts of cannabis and the possible consequences of different policies;*

That the special committee consist of five senators, three of whom shall constitute a quorum;

That the Honourable Senators Banks, Kenny, Nolin, Rossiter and (a fifth Senator to be named by the Chief Government Whip) be named to the committee;

That the committee be authorized to send for persons, papers and records, to hear witnesses, to report from time to time, and to print from day to day such papers and evidence as may be ordered by it;

That the briefs and evidence heard during consideration of Bill C-8, An Act respecting the control of certain drugs, their precursors and other substances and to amend certain other Acts and repeal the Narcotic Control Act in consequence thereof, by the Standing Senate Committee on Legal and Constitutional Affairs during the 2nd Session of the 35th Parliament be referred to the committee;

That the documents and evidence compiled on this matter and the work accomplished by the Special Senate Committee on Illegal Drugs during the 2nd Session of the 36th Parliament be referred to the committee;

That the committee be empowered to authorize, if deemed appropriate, the broadcasting on radio and/or television and the coverage via electronic media of all or part of its proceedings and the information it holds;

That the committee present its final report no later than August 31, 2002; and that the committee retain the powers necessary to publicize its findings for distribution of the study contained in its final report for 30 days after the tabling of that report;

That the committee be authorized, notwithstanding customary practice, to table its report to the Clerk of the Senate if the Senate is not sitting, and that a report so tabled be deemed to have been tabled in the Senate.

ORIGINS

The Committee's mandate is a continuation of the history of drug legislation passed by the Parliament of Canada in 1996, the *Controlled Drugs and Substances Act.* That legislation, which revised drug statutes in Canada by repealing the *Narcotic Control Act* and certain sections of the *Food and Drugs Act*, grew out of a relatively lengthy history of which we will provide only a brief overview here, since Chapter 12 is devoted to a detailed history of drug laws in Canada.

Bill C-7, which was tabled by the newly elected government in February 1994, proposed a revision of illegal drug legislation, in particular to make it more coherent and to render national legislation consistent with Canada's obligations under the *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* signed in 1988. Following prorogation, it was reintroduced in the House of Commons at the start of the 2nd Session, on March 6, 1996, as Bill C-8. It was adopted by the House on the same day and was referred to the Standing Senate Committee on Legal and Constitutional Affairs which conducted a detailed study of it and heard a number of witnesses.

In its report, the Senate Committee on Legal and Constitutional Affairs proposed 15 amendments as well as the striking of a joint parliamentary committee of the House of Commons and the Senate, which would review Canada's drug policy. Bill C-8 was passed and received Royal Assent on June 20, 1996, and is thus Canada's current illegal drug legislation.

While this legislation was being studied by the Sub-Committee on Bill C-7 of the Standing Committee on Health of the House of Commons in 1994 and 1995, "*the vast majority of witnesses (...) were highly critical of the bill. The most general criticisms concerned three points: first, the lack of basic principles or an express statement as to the purpose of the act; second, the fact that the bill followed the prohibition system of the 1920s, subsequently codified in the Narcotic*

Control Act, and third, the absence of any emphasis on damage reduction and prevention criteria which form the basis of Canada's Drug Strategy."[2] Despite the amendments made by the Sub-Committee of the House, the testimony of the persons heard by the Senate Committee was equally critical. Witnesses noted that the Act did not categorize drugs on the basis of the dangers they represented, that it did not contain any specific, rational criteria and that it was impossible, particularly in view of the Act's complexity, to determine how it would be implemented in practice.

All of these criticisms led the Senate Committee to "*propose energetically*" the creation of a Joint Committee of the House of Commons and the Senate that would review all Canadian drug legislation, policies and programs.[3]

However, the 1997 federal election rendered this suggestion moot. Senator Nolin, convinced of the need for action and faced with the inaction of the House of Commons, thus tabled his first motion in 1999 - that a Senate Committee be struck and given a mandate to examine the legislation, policies and programs on illegal drugs in Canada. The motion was adopted by the Senate in April 2000. In support of the motion, Senator Nolin had commissioned a study on drugs and drug policy in Canada. The purpose of this study, in particular, was "*to assist in analyzing policy on the control of drug use from a new angle, without being influenced by the often unfounded prejudices that Canadian society has of drug addicts*".[4] Senator Nolin wrote further that a Senate Special Committee "*would be charged, first, with transmitting to the Canadian public accurate and objective information on the use of illegal drugs, their effects on individuals and society and control measures in place. Second, it could conduct consultations on desirable amendments that Parliament should make to legislation on the control of drug use in the years to come.*"[5]

INTERPRETATION

Our mandate comprises four components:

1. Examine the federal government policy on cannabis, the means used to implement it, its control and its effectiveness;
2. Examine the policies and approaches followed in other countries;
3. Examine the implications of the international conventions and treaties; and
4. Examine the social and health effects of cannabis and the possible impacts of different policies.

---

[2] Allain, J. (1997) *Bill C-8:Controlled Drugs and Substances Act.* Ottawa, Library of Parliament, page 35.

[3] Standing Senate Committee on Legal and Constitutional Affairs, Eleventh rapport, June 1996, page 8.

[4] Nolin, P.C. (1998) Preface. In Riley, D. (1998), *Drugs and Drug Policy in Canada. A Brief Review and Commentary.* Ottawa, page 10.

[5] *Ibid.*, page 11.

We chose to interpret our mandate in the broadest manner possible. Some asked us whether it was our ambition to be a second Le Dain Commission.[6] Others told us we did not have the resources to be so exhaustive and rigorous in our examination. Still others regretted the fact that we were restricted in the first phase of our work to cannabis, as though the various substances could be separated and their users classified accordingly.

Chapter 2, on our work program, will show that we were motivated by a desire to be rigorous and to cast our net wide. We are nevertheless aware of the scope and limits of our role as a Senate Committee, all the more so since the means put at our disposal were as limited as our ambition was generous.

The question of the distinction among substances is more problematical for various reasons. First, recent research shows that it is more important to distinguish between user behaviours than between substances. Based on this view, it is thus not so much the drugs themselves that should be distinguished as the different ways in which they are used and the environments in which those uses take place, and hence the risks a certain number of users run. Here we will discuss at-risk behaviours[7], which are not determined so much by the characteristics of the substances as by those of the users and the conditions in which they are used. Second, the distinctions between substances have no clear scientific basis. Thus, entirely different classifications are arrived at depending on how one views the pharmacological properties of the various drugs, their effects on physical health and their origins or cultivation methods. And third, a comprehensive and integrated drug policy cannot be put forward on the basis of this distinction between substances.

However, the result of this decision, which forced us to limit our work to cannabis, was something more than just disadvantages and limits. We should admit, first of all, that embracing the entire field of illegal drugs with so little in the way of resources would have been a monumental undertaking. And as recent commissions of inquiry and international scientific conferences have chosen, as we did, to survey the state of knowledge on cannabis, we were able both to make use of their work and to compare it to our own. Lastly, and more particularly, experiments conducted in other countries, in particular the Netherlands, demonstrate the merit in treating cannabis separately, in a "market separation" approach.

In short, while restricting our work to cannabis, we invited the witnesses not to limit themselves to it alone and to show us the links between it and the various at-risk behaviours of users when they occur. We also bore in mind the necessity of addressing

---

[6] The Le Dain Commission, which investigated illegal drugs in the early 1970s, will be discussed more fully in Chapter 12. See Canada (1970), *Interim Report of the Commission of Inquiry into the Non-Medical Use of Drugs.* (Le Dain Commission) Ottawa: Queen's Printer.

[7] See among others: Reynaud, M., P.J. Parquet et G. Lagrue (1999) *Les pratiques addictives. Usage, usage nocif et dépendance aux substances psychoactives.* Rapport préparé à la demande du Directeur général de la Santé. Paris: Secrétariat d'État à la Santé et aux Affaires Sociales.

drugs in the context of an integrated policy, particularly with regard to the major parameters of public policy, legislation or knowledge infrastructure, for example.

CHAPTER 2

OUR WORK

Designing, developing and implementing public policy is the very essence of the role of government, of political life in the broad sense. This fundamental activity presupposes a choice between various alternatives and, in a democratic system, an explanation and justification of the choice that has been made. A public policy, regardless of its object, stands at the confluence of various influences: partisan political considerations of course, economic considerations as well, even increasingly so. However, if it lays claim to a certain degree of rationality and citizen support, a public policy must also be based on rigorous and objective data, preferably from scientific research, and on an understanding of society's expectations and resistance. Lastly, a public policy, in our view, should be founded on, and at the same time promote, guiding principles. By that, we mean a clear and express vision of the principles that guided the choice among various alternatives and that reflect a conception of government and of the relationship between government institutions and civil society.

From the outset, our Committee chose to remain above partisan issues. This is the advantage of belonging to the Senate, which makes it possible to take, on various questions, a more objective view not influenced by concern for re-election. Economic considerations affected us in two different ways. The first, a trivial matter, was related to the budgets allocated to us, which necessarily limited the scope of our work, the second to the economic impact of various public policy options which are discussed in Chapters 18 and 21.

Our work thus focused on the other three sources that should influence a choice of public policy on illegal drugs: knowledge, public opinion and guiding principles.

At the Committee's public hearings, the Chair presented the research program as follows:

> *In order to fully satisfy the mandate conferred upon the committee, the committee has adopted an action plan. This plan centres around three challenges. The first challenge is that of knowledge. We will be hearing from a wide variety of experts, both from Canada and afar, from academic settings, the police, legal specialists, medical specialists, the government sector and social workers. (...)*
> *The second challenge, surely the most noble challenge, is that of sharing knowledge. The committee hopes that Canadians from coast to coast will be able to learn and share the information that we will have collected. In order to meet this challenge, we will work to distribute this knowledge and make it accessible*

> *to all. We would also like to hear the opinions of Canadians on this topic and in order to do so, we will be holding public hearings in the spring of 2000 throughout Canada.*
> *And finally, the third challenge for this committee will be to examine and identify the guiding principles on which Canada's public policy on drugs should be based.* [1]

This chapter describes the various measures we took to ascertain the state of knowledge and public opinion on cannabis and to determine guiding principles. Chapter 3 presents our guiding principles in detail, while Parts II and III outline all the information we were able to gather. First, however, a few words on two working principles which we considered essential to the complete realization of this Committee's mandate.

TWO WORKING PRINCIPLES

In view of the formulation of our mandate, which included an obligation to provide Canadians with objective and rigorous information, we have emphasized rigour and openness throughout the entire process.

It was all the more imperative that we do our work in a rigorous manner since opinions on all sides of the illegal drugs issue are strong and often categorical. Like everyone else, we too had our opinions and preconceptions regarding illegal drugs when we began our work. How could it be otherwise? Like you, we have children. We have had friends and relatives whose lives have been ruined by addiction problems. Our study of the government bill (C-8), which afforded us the opportunity to hear from a certain number of stakeholders and experts, provided us with information, of course, but also revealed major gaps in our knowledge. It then seemed clear to us that opinions were often based on partial and at times incorrect information. On what basis can it be said that cannabis leads to the use of other drugs? What is the empirical basis that supports the notion of cannabis dependence? What leeway does a nation have under the provisions of the international conventions governing the production, trafficking in and possession of illegal drugs?

One cannot assert both one thing and its opposite. However, on the subject of drugs, and specifically cannabis, such very assertions were made to us, and with conviction. How to determine who was right? And to tell opinions from facts?

These findings convinced us that the highest degree of rigour was necessary in the course of our work, as will be seen in the next section.

But rigour is not enough. For this information to reach Canadians, we could not reserve it for our exclusive use, hence the second principle that guided us: openness. From the outset, we insisted that all our work be made available as soon as possible on

---

[1] Senate of Canada (2001) *The Proceedings of the Special Committee on Illegal Drugs.* Issue No. 1, page 23.

our Web site. There was nothing new in posting witnesses' testimony to a Web site, since this is common practice for most parliamentary committees. However, in addition to this testimony, we also posted a number of studies we had commissioned, many from the Parliamentary Research Branch of the Library of Parliament. These studies, which are often not made public until after a Committee's report is published, were made available to Canadians as they were completed.

Being legislators, we would of course like our work to have an impact on public policy. We also believe it important to provide Canadians with information that is as factual as possible to allow them to benefit from it.

STATE OF KNOWLEDGE

When the Commission of Inquiry into the Non-medical Use of Drugs conducted its work in the early 1970s, like most commissions of inquiry, it had a large staff and budgets enabling it to carry out a vast research program. That was all the more necessary since, at the time, no large pool of knowledge on illegal drugs existed. Virtually nothing was known about the active ingredients of cannabis or even about the pharmacological properties of more traditional drugs, such as heroin and cocaine, and little was known about user trajectories; criminological studies on the relationship between drugs and crime were virtually non-existent, and public policy impact studies were in their earliest stages.

To say the situation has completely changed would be an understatement. In all scientific disciplines, from molecular biology to anthropology, countless studies have been conducted over the past 25 years on illegal drugs in general, and cannabis in particular. They come from the United States, of course, but also from Australia, England, France, Switzerland, Italy, Germany, Sweden, Finland and Denmark to name only a few. They have been conducted by academics interested in these questions on a purely individual basis, by pharmacological laboratories and by research groups within organizations operating in the drug addiction field and in the context of scientific commissions appointed by the governments of various countries.

The Committee asked the Parliamentary Research Branch to prepare a survey of illegal drug research under way or completed in the past five years at the federal level and in the provinces and territories.[2] That survey, which lays no claim to being exhaustive, but offers an overview of the extent and scope of recent research, clearly shows that, despite minuscule budgets compared to those allocated in the United States, research on illegal drugs is doing relatively well in Canada. We can only imagine

---

[2] Leduc, D., et al., (2001) *Federal Research on Illegal Drugs and Related Issues.* Ottawa: Library of Parliament; and Miller Chenier, N., & S. Norris (2002) *Territorial Research on Illegal Drugs and Related Issues.* Ottawa: Library of Parliament. Reports prepared for the Senate Special Committee on Illegal Drugs. Available at www.parl.gc.ca/illegal-drugs.asp.

that it would be a formidable task to survey the studies under way in the United States on the question of illegal drugs.

Ascertaining the state of knowledge on the subject thus first meant finding the means to prepare a rigorous synthesis. To that end, the Committee adopted a research program focusing on all aspects. However, as it lacked the financial resources to produce an extensive series of studies, and also wishing to ensure that the information was broadly transmitted to the public, the Committee designed a program of public hearings of expert witnesses who would likely be able to assist in more clearly determining the state of current knowledge on the subject.

The Committee approved a research program divided into five major axes of knowledge, sub-dividing each one into specific issues:

- *The socio-historical, geopolitical, anthropological, criminological and economic issues of the use and regulation of cannabis.* This axis of work will establish the context for a better understanding of modern practices in the production and use of cannabis. The main questions are:
  - What are the key historical patterns in the production, use, consumption and circulation of cannabis?
  - Is there a relationship between cannabis use and religious or cultural practices?
  - What are the relationships between the production, use, consumption, and circulation of cannabis and the socio-demographic characteristics of populations? More specifically, what do we know about cannabis users?
  - What are the key domestic and international drug routes and how are they related to national and international political and policy issues?
  - What are the relationships between various drugs and how have current distinctions between licit and illicit drugs been created?
  - What are the relationships between the production, use, consumption, circulation and regulation of drugs and criminality?
  - What are the key economic issues in the production, use, consumption, circulation and regulation of cannabis?

- *The medical and pharmacological aspects of the consumption, use and regulation of cannabis.* The use of cannabis for medicinal purposes occupies an important place in current debates on regulatory systems governing it. The idea here is to produce state of the art reviews on knowledge related to the physiological and psychological effects of various drugs. The key research questions are:
  - How has cannabis been used for medicinal purposes?
  - What is the state of knowledge on the therapeutic properties of cannabis?
  - What is the state of knowledge on the physiological effects of cannabis, especially in respect of addictive capacity?

- What is the state of knowledge on the psychological effects of cannabis, especially in respect of dependence?
- What is the current state of knowledge on the effects of various forms of treatment for dependence and addiction problems, their impacts and their costs?

❖ *The legal aspects from a national perspective.* Federal legislative mechanisms exist in Canada to control the use, consumption, production and circulation of drugs, even though treatment and other areas, for example, are under the jurisdiction of the provinces and territories. Additionally, the courts have interpreted the relevant acts and regulations, particularly regarding policing powers. Overall, this section will examine the legislative and control arsenal, its rationality and objectives, from the standpoints of criminology, law, history, sociology and economics. The key questions guiding this third axis of the research program are:

- What are the history of and logic to the different regulatory and control modes of cannabis in Canada?
- What are the history and logic behind criminalization and penalization in Canada?
- What is the state of case law in respect of the legislative and regulatory arsenal relating to the production, use, consumption and circulation of drugs in Canada?
- What is the state of case law on police powers and sentences in relation to drug issues?
- What are the effects of criminalization and penalization in matters of drugs on the justice system (and its various components), the prison system and the criminal careers of delinquents?
- What are the economic and social costs of the various modes of regulation, control and criminalization in matters of drugs?
- What are the relations among justice and public health policies and government departments in matters of drugs?

❖ *The legal and political issues in an international perspective.* Canada is a party to various treaties and conventions on the production, trafficking and possession of psychoactive substances. It was important to assess how precise and binding these instruments are on domestic legislation. Also, these treaties and conventions are themselves part of a larger array of international instruments, especially on human and political rights; it was essential to determine the interrelationships between these instruments. Finally, drugs are an issue in international relations, in particular in relations between Canada and the United States. Although not legally binding, these factors may influence policy reorientations and will thus be interesting to look at. The key questions are:

- What are the main treaties and conventions in matters of drugs, their history and their provisions?
- What constraints, if any, do these treaties and conventions impose on Canada?
- Beyond treaties and conventions, what other aspects of international relations have implications for Canada in adopting a regulatory mode in matters of drugs?
- What are the regulatory approaches adopted by other countries, what are their impacts, and to what extent are they pertinent for Canada?

❖ *The ethical issues and Canadians' moral and behavioural standards.* Ethical issues and knowledge of the standards adopted by Canadians are also relevant in determining policy and legislative orientations. The key questions are:
- What are the ethical principles relevant to examining issues related to the production, use, consumption, circulation and control of drugs?
- What are the pertinent ethical principles in relation to the medicinal use of cannabis and the medical and psychological treatment of drug addictions and dependence?
- What are the current norms of behaviour of Canadians in relation to cannabis production, consumption, use and circulation?
- What are the norms of tolerance of Canadians?
- To what extent do ethical principles and norms of tolerance in the population accord?

As can be seen, the undertaking was a vast one. In an attempt to answer these questions in the most effective and most economical manner possible, the Committee agreed to perform two tasks concurrently: conduct a research program and hear expert witnesses–complementary activities.

__Research program__

Lacking both a research budget that would have enabled us to commission studies and a full-time research staff, we asked the Parliamentary Research Branch to produce syntheses and analyses of the relevant literature.[3] The research is divided into three major categories:

---

[3] A complete list of the studies produced by the Parliamentary Research Branch is provided in Appendix 3. All the research reports are available on line at the Committee's Web site: www.parl.gc.ca/illegal-drugs.asp. The Committee wishes to express its appreciation of the work performed for it by the Parliamentary Research Branch.

- Legal studies: analyses of case law and international conventions and treaties;
- Socio-criminological studies: analyses of the relationship between drugs and crime, of developments in denunciations, charges and sentences; cannabis use practices; economic aspects of drugs;
- Comparative studies: syntheses of public policies in certain countries.

We also received a synthesis of the literature on the physiological and psychological effects of cannabis.[4] Lastly, we commissioned a qualitative study on Canadians' opinions and attitudes by a public survey firm.[5]

In all, the Committee received 23 reports and benefited from summaries of work conducted in other countries, particularly through its attendance at international conferences.

Expert Witnesses

Aware of the research program's limits, and particularly of the need to question some of the researchers whose work was cited in the studies conducted and to compare their analyses with those of other researchers and with the positions of other expert organizations (police forces, for example), we conducted a series of hearings of expert witnesses in Ottawa and certain other cities across the country.[6]

The hearings began on October 16, 2000 during the 36[th] Parliament and resumed on April 30, 2001, during the 37[th]. They ended on June 10 of this year with presentations from the principal departments responsible for illegal drug policy in Canada. As far as possible, the Committee maintained a rate of one hearing every two weeks.

In every case, the Committee asked the witnesses to prepare a written brief responding to specific questions. The Committee did not expect the experts to give their opinion or tell it what to think. The expert witness hearings were part of an effort to increase members' knowledge. Knowing that our ability to conduct studies was limited and acknowledging that research data were incomplete, if not contradictory, we wanted to take full advantage of this exceptional opportunity to clarify and better disseminate certain findings.

---

[4] Wheelock, B. (2002) *The Physiological and Psychological Effects of Cannabis: A Survey of the Literature.* Document prepared for the Senate Special Committee on Illegal Drugs. (The Committee particularly wishes to thank Senator Rossiter, who made the preparation of this paper possible.)

[5] Léger Marketing (2002) *An Exploratory Study Among Canadians on the Use of Cannabis*. Montréal: author. Report prepared for the Senate Special Committee on Illegal Drugs. Available at www.parl.gc.ca/illegal-drugs.asp.

[6] A complete list of the witnesses heard as well as subjects, places and dates is provided in Appendix 2. All the evidence and certain supplementary documents provided by witnesses are available on line at the Committee's Web Site.

Who were these experts? How did the Committee select them? These are important questions to the extent that a certain number of stakeholders questioned the Committee's credibility as a result of certain choices it made. First, we wanted to cover each of the major fields of investigation. Consequently, we heard sociologists and lawyers, psychologists and physicians, police officers and criminologists. Second, we wanted to hear as many Canadian experts as possible from those various research areas. Third, for the most part, we selected experts known for their publications in the field. The researchers included Professors Harold Kallant and Marie-Andrée Bertrand, who were closely involved in the work of the Le Dain Commission 30 years ago and researchers closely associated with such major institutes as the Ontario Centre on Mental Health and Addiction (the former Addiction Research Foundation) and the Canadian Centre on Substance Abuse. Lastly, we were interested in inviting experts who, in certain cases, could speak on behalf of major institutions such as the Canadian Medical Association, the Federation of Canadian Municipalities, the Canadian Association of Chiefs of Police and the Royal Canadian Mounted Police. It will be seen from a close look at the list of experts heard and the subjects of their presentations that they coincided with all our areas of concern.

When the hearings focused on the situation in other countries, we sought to strike a balance between those persons who could describe public policy and researchers whose work was recognized in their country and internationally. As the number and length of our hearings were limited, we had to make choices. At most we could hear four persons per hearing. As a general rule, we tried to choose a senior government official and three researchers.

One could also question our choice of countries heard: France, the Netherlands and Switzerland. We had initially intended to hear representatives from England, particularly because that country's public drug policies have been examined in many high-quality studies. Unfortunately, changes under way in there prevented us from holding those hearings. Similarly, we did not have enough time to hear from Sweden or Australia. However, we had the Parliamentary Research Branch prepare syntheses on each of those countries.

The case of the United States deserves particular attention. Chapter 20 describes American drug policy. However, at our hearings on the United States, which is much more complex and less monolithic than is often thought, we were unable to hear from those responsible within the U.S. government, although not for lack of trying. The Director of the prestigious National Institute on Drug Abuse (NIDA) had tendered his resignation a week before the scheduled date of the hearings, after accepting our invitation. And the Director of the Office of National Drug Control Policy in Washington declined our invitation. In short, we are dissatisfied at having been unable to hear the senior officials responsible for drug policy in the United States. Nevertheless, on June 10 2002, we held a private meeting with Dr. Hanson, the new Director of NIDA, and on June 11 we had an *in camera* meeting with Mr. Walters, the Director of ONDCP and some of his key advisors in Ottawa.

In all, the Committee held more than 40 days of public hearings in Ottawa and other Canadian cities, hearing more than 100 persons from all backgrounds.

One further note. It can be said that we did not handle the testimony of researchers and those of practising experts in the same way. That is true in part. To the extent that researchers presented data lending itself to critical review, containing verifiable data, which does not mean proof, on specific subjects, making it gradually possible to answer our empirical questions, we attached a certain degree of importance to them, which will be reflected in the passages cited throughout this report. The information from practitioners is not in itself any less significant or important in our view. However, the practitioners more often tended to express opinions than to present study data. They also did not have the same concern to give precise answers to the questions put to them. Those opinions are important, as are those of the Canadians whom we heard and who wrote to us, but they are nevertheless opinions, not cold hard data.

The challenge of synthesis

Faced with this massive amount of information, the greatest challenge was to synthesize it. The scientific literature on all of the topics addressed, particularly those concerning the effects of cannabis and users and types of use, is abundant. Experts reported to us on their research and that of other researchers. The reports prepared at our request are full of information, and our research team stayed on the look-out for recent publications and attended various international scientific conferences. In short, the task was to make sense of all this data, which, in addition, contained contradictory information at times.

At the same time, the data on certain subjects are still fragmentary. This is the case of data on trends in the use of cannabis and other drugs in Canada (Chapter 6), on the specific nature of therapeutic applications of cannabis, evidence of which often does not go beyond the anecdotal (Chapter 9) and simply on police practices (Chapter 14) or the decisions of Canadian courts (Chapter 15).

Synthesizing this information thus also meant making choices. While fully respecting the diverse range of perspectives, we nevertheless had to draw conclusions, accepting that some of the conclusions might be preliminary and that they might be contradicted by subsequent research. It is in the very nature of science that it is constantly in motion, and we accept that state of affairs. As a result, we are aware that we have left ourselves open to criticism. So much the better, we might add, first, because criticism will stimulate public debate, second, because it will undoubtedly pique the curiosity of researchers, who will verify some of our findings empirically, thus improving the state of our present knowledge, and, third, because our choices will be made plain in light of the guiding principles that are outlined in the next chapter.

TAKING OPINIONS INTO ACCOUNT

Public opinion is hard to grasp, first, because it does not exist in itself but is created by the manner in which the pollsters' questions are asked, by the manner in which the media report a debate, and by a broader context of representations the actual determinants of which are never precisely known.

Understanding public opinion on a complex subject such as drugs is not a simple matter such as discovering what type of laundry detergent respondents will buy at the supermarket. A seemingly simple question quickly becomes complex once Pandora's box is opened. A public opinion poll may ask the public whether they are in favour of decriminalizing cannabis. However, do we know whether every respondent understands the term "decriminalization" in the same way? The complex nature of this term is addressed in Chapter 21. Do we know whether respondents are for or against decriminalization for the same reasons? And once it has been determined that a majority is for or against it, do we know how that public policy choice would be implemented?

If it is the case, taking opinions into account is a necessity in a democracy. For us, taking opinions into account meant we had two closely related responsibilities: first, it meant we had a duty to inform, indeed to educate, although we hope those who are offended by that term will pardon us for using it, but we are convinced that on public policy topics, which are societal issues, it is the duty of political leaders to transmit information that educates, not merely convinces. The level of knowledge about drugs, even about cannabis which is the best known drug, is often limited and wrapped up in numerous myths. Our second responsibility in taking public opinion into account was to go and discover it. We did so in three ways.

First, we publicized our work as widely and as openly as possible to enable everyone to learn about it and react to it. Many chose to do so by writing to us, although they were relatively few compared with the number of people in this country.

Second, we commissioned a qualitative public opinion study. The focus groups conducted across the country as part of that study are described in detail in Chapter 9.

Third, we held public hearings in various cities across the country (eight in all), thus enabling a certain number of citizens to come and tell us what they thought, what they knew and what they had experienced.

We are aware that informing and seeking public opinion also means having a hand in forming it. It is thus not a neutral activity.

INTERPRETING IN LIGHT OF PRINCIPLES

All this knowledge, in the form of research and public opinion, still needs to be interpreted. Scientific knowledge is subject to constant verification. It at times contains

contradictions, as will be seen in Chapters 7 and 8 in particular. Knowledge of public opinion necessarily remains fragmentary and evolving. Thus the importance of interpretation.

Beyond this, a public policy, as noted above, is not based on knowledge alone, no matter how rigorous. Guiding principles are necessary, principles that can permit an informed interpretation of data and assist in the establishment of conclusions. This is the subject of the next chapter, which will describe the method we used to determine our guiding principles and the principles themselves.

CHAPTER 3

OUR GUIDING PRINCIPLES

What should public policy on illegal drugs consist of, policy here being understood in the strict sense of the word, as government through public debate and not party politics? As we are part of the Senate of Canada and therefore of Parliament, and having legislative authority, one might wonder why we ask ourselves the question. As legislators, are we not guided by the principles of good government, that is to say by public interest? In fact, what is public interest, and how is it determined? Does our position as Senators give us the *de facto* ability to say what is, or what should be, in the interest of Canada? We do not believe so.

When faced with social issues such as illegal drugs, we are like all Canadians, struggling with our beliefs, our knowledge, our values, our doubts and our myths. Our special access to some one hundred expert witnesses, our reading of numerous research papers and our discussions with dozens of people across the country have forced us to confront our preconceived ideas and images about drugs and to compare them with those of "others", and if not to change them, at least to refine them along the way. However, this is not sufficient to determine what is in the public interest. Experts, no more so than the many citizens we heard from, do not determine what is in the public interest. Studies show only the most superficial aspects of what Canadians think. In addition, when polls that are more sophisticated provide us with a more in-depth picture of public opinion, we will be no further ahead in trying to decide on the direction that public policy on cannabis should take. This is primarily because the greater good is not determined by polling to see which way the winds of public opinion are blowing, and also because, as is the case with our personal opinions, public opinion relies on unverified information, on preconceived ideas that are sometimes biased, and on values that are not always clear.

We heard quite frequently that the public policy decisions should be based on the future of our children, on the kind of society in which we wish to live and that we wish to leave them. Over the last two decades, Canadian society has implemented costly anti-smoking programs. Do we want to be in conflict with these by allowing the smoking of cannabis? Cannabis is a psychoactive substance that can impair certain cognitive abilities linked to learning in young people. Do we want to send the message that it is okay for them to take drugs?

Others said that the fundamental values of Canadian society, values of respect for people's rights and freedoms, of tolerance and openness towards diversity, were compromised by existing legislation on cannabis. They added that these laws are no longer in step with society, reflecting an inter-generational conflict between adults and youth, they bring about more harmful consequences than good, and on top of being ineffective they are iniquitous.

This is an issue of values, therefore, which opposes various ideas about public health, of community health, meaning both the physical well-being of people as well as of the entire community, of its moral fiber as well as the model of inter-relationships that it proposes. However, we do not all share the same values.

In the fragmented, disillusioned world in which we live, a world open to the sharing of cultures and of identities, albeit not always by choice, the issue of values is constantly at stake, and from this the very meaning of social life. Even the transcendental values that we all share, of sacred respect for life and of immanent justice, are not readily turned into public policy: abortion or capital punishment, for example. As for other values, such as freedom, truth or law, they are the subjects of constant debate in democratic societies and they are precisely the kinds of values that are at stake in a public policy on illegal drugs.

It has now been thirty years since the Royal Commission of Inquiry on the Non-Medical Use of Drugs, the Le Dain Commission, named for its Chairman, studied issues similar to those we are studying today. Its report on cannabis, whose scientific conclusions on the effects of the drug were generally accepted by all members of the commission, nevertheless led to … three reports: a majority report by three of the members, and two minority reports. During our first day of public hearings, Professor Line Beauchesne presented the fundamental differences of opinion among the members:

> *The dissension stems primarily from different visions of the values that should underlie a drug policy. I will refer to the report to illustrate the three positions that can be taken on drug use.*
> *The first position, based on legal moralism, is that advocated by Ian Campbell. This public policy approach founded on legal moralism justifies the current prohibition and resulting repression on the grounds that it protects common values. (…) Briefly put, the government is perceived as having the responsibility of establishing common values, which are then imposed on society with a view to achieving optimum social harmony. If everyone thinks the same way, then there will be fewer problems.*
> *(…) The second position, held by the majority of the Le Dain Commission members, is based on legal paternalism. Public policy based on legal paternalism justifies current prohibitions on the grounds that the State has a responsibility to protect non-independent persons, particularly young persons.*
> *(…)*
> *When we come to the third position, that taken by Marie-Andrée Bertrand advocating the legalization of cannabis, this brings us around to the whole question of values (…). Legal liberalism implies that the government maintains some responsibility for preserving individual autonomy to the maximum extent possible. (…) A public drug policy based on legal liberalism is founded on the premise that the*

government's role is to maximize opportunities for each individual to be a full citizen and to ensure that criminal law is never used. [1]

Moralism is an affirmation of a set of shared values. Paternalism is protection of the weak. Liberalism is maximization of the independence of citizens. These three categories do not include all of the possibilities: communitarianism, for example, represents another approach. In some areas of public policy, at certain times, these various approaches can co-exist. Nevertheless, each one expresses a different concept of the role of the State and of criminal law, and the roles of science and ethics in the choices that must be made.

Having examined each of these subjects, we have elected to set down the guiding principles that clarify the concept we have of the roles that the state, criminal law, science and ethics must play in the development of a public policy on cannabis. These principles will then help us in our analysis of the information resulting from the research and current practices in Canada, and most of all, influence our recommendations. In this way, the reader will have the benefit of our attempts to make explicit the principles which all too often remain implicit, therefore giving the opportunity to all to take us to task for inconsistency, or to voice their disagreement with our conclusions, because they do not share these principles. We feel this exercise has the virtue of being both clear and transparent.

In order to assist our preparations for this work on the guiding principles, we asked four Canadian academics, well known both in their respective fields and for their independence, to prepare issue papers on each of the four main themes: governance, criminal law, science and ethics.[2] We strongly encourage Canadians to read these texts, which are of an exceptional richness and quality. We will use these texts freely, without pretending to render the complexity of their thinking, but neither will we simply echo their sentiments. Just as we did not ask witnesses to tell us what to think, but rather to share their knowledge with us while being as rigorous and as precise as possible, whether their knowledge comes from research or from experience, so we asked for issue papers and not for answers to our questions. We must formulate our own responses to the illegal drug issues before us, and that is what is expected of us.

We will begin with a reflection on ethics. We feel that such an examination, insofar as it affects the very bedrock of our values, as it imposes a requirement for

---

[1] Professor Line Beauchesne, witness appearing before the Special Committee on Illegal Drugs, Senate of Canada, Second session of the Thirty-sixth Parliament, October 16, 2000, Issue 1, pages 33-36.

[2] They are: R. Macdonald, Professor of Public and Constitutional Law, McGill University, *The Governance of Human Agency;* A.P. Pires, Professor of Criminology, University of Ottawa, *Legislative Policy and "Two-Sided" Crimes: Some elements of a pluridimensional theory of the criminal law;* T. de Koninck, Professor of Philosophy, University of Laval, *The Role of Knowledge and Culture in Public Policy on Illegal Drugs*; and J.F. Malherbe, Professor of Social Work, Université du Québec à Montréal, *The Contribution of Ethics in Defining Guiding Principles for a Public Drug Policy.* These texts are available on line at: www.parl.gc.ca/illegal-drugs.asp.

communication and dialogue[3], is the cornerstone upon which the other guidelines are based. Our principles dealing with governance – that is to say the role of the State – and with criminal law as a tool for achieving social conditions, then, hinge on this ethical concept. We will conclude with thoughts on the role of science, or more specifically of knowledge.

ETHICS, OR THE PRINCIPLE OF RECIPROCAL AUTONOMY

Let us assume that science, with supporting evidence, had shown the harmfulness of a given drug – say tobacco – and that it is a "cause" of serious, indeed fatal illnesses. To what extent are doctors, judges, and in the end, the State, authorized to go to ensure that people do not smoke? What limits are there on intervention? This is the question posed by ethics, more specifically the ethics of "health". Should we simply ban tobacco and punish both its users and its producers? Should we educate people through prevention campaigns? Should we discourage smokers through their pocketbooks, for example with a surtax for the hospital care that their habit could make necessary?

We see that ethical reflections take us through what is, through the realm of facts, to the realm of what should be, of what would be desirable. Moving therefore from recognized facts (that cigarettes "cause" lung cancer) to standards (the majority recognizes that smoking is harmful), but, more important than standards, to values (health is the greater good) and finally to the means of passing on and above all implementing these values (smoking is forbidden and subject to a fine). At any of these steps, one could speak out and say just a minute, I do not agree. I do not agree with the statement of fact: what is the basis of, what studies support this "finding", one might ask. I do not agree with the standard: even though a public opinion poll may show that most people believe cigarettes cause lung cancer, is that reason enough to put an end to the debate? I do not agree with the established values: freedom is the greater good and not health - what is the use of being in good health under a totalitarian regime? Finally, disagreeing with the means chosen to implement the value - it being unacceptable to

---

[3] On this subject, see the work of the German sociologist and philosopher Jürgen Habermas, particularly *De l'éthique de la discussion*. Paris : Cerf. The author presents the process of ethical discussion as follows: Through debates, all participants must acknowledge that, in principle, each person participates fully, freely and equally, in the cooperative search for truth in which the unlimited strength of the best argument will carry the day. Practical discussion is considered as a demanding form of argumentative training of the will, which (…) must guarantee, through the universal presuppositions on communication, the fairness of all possible normative agreements negotiated under these conditions. (…) Furthermore, practical discussion is considered to be a process of inter-comprehension in which, due to its own nature, all participants ideally adopt a role. Therefore, the individual and ideal adoption of a role played by each person in particular and *privatim* is transformed into a practical public operation by all, intersubjectively and in common. (pages 18-19).

ban cigarettes under the pretext that they cause cancer because the means is disproportionate to the fact.

Anyone who has followed the debates on cannabis to any degree will have drawn a parallel. Because cannabis "causes" health problems (both physical and moral), the standard states that its use is "dangerous" and, under the banner of public health values (and of the protection of the most vulnerable: children, adolescents, etc.), its production, manufacture, sale and use, etc. will be prohibited. This is the basis of the existing public policy.

As Professor Malherbe reminds us, this way of setting out the cannabis problem – as in fact is true for other substances – encourages us to rethink our ideas on health, medicine and science. Moreover, going one step further, it obliges us to consider the issue of risk and of life itself in society.

We live in a risk-taking society, but in a paradoxical manner. On the one hand, we place great value on risk-taking: venture capital, risk management, putting no limits on success. We see this as much in the appreciation of certain kinds of political or corporate decisions, as in the emulation of certain kinds of risky activities, such as Formula 1 racing, paragliding, and other extreme sports. On the other hand, we are becoming intolerant of risks of life in society, of the risks that others represent to our individual lives. It is a search for safety, both individually and collectively, vis-à-vis the smalltime crook or the terrorist. Risk would be in conflict with safety and security as illness would be in conflict with health.

Between these two apparently opposed attitudes towards risk, a subtle change in connotation slips in and partly explains the paradox. In the first sense (risks we like to take or will accept others taking), the issue is clearly risk. Here, risk is seen as being positive, and offers a number of options: when faced with this kind of risk, the person can decide to forge ahead, to wait, or to give up. In any case, there is a broadening of possibilities, therefore of autonomy, an extension that is no doubt linked to the admiration these people elicit, which is also tinged with envy as we observe this action that our position as "mere mortals" rarely permits us. The shift in meaning happens with the second sense, which does not relate to our ideas on safety but rather of danger. Safety is a collective and individual good, as in food or occupational safety. Danger, on the other hand, is usually a loss or a limitation of freedom of action: when faced with danger, most of us stop, and withdraw from the scene. In this sense, danger reduces the range of autonomy. Therefore, it is not safety that is in conflict with risk, but rather danger.[4] The distinction is fundamental, because it refers us to the degree–whether real or perceived–to which we control our own existence. We sense that the "crazy Canuck" bombing down the slopes is at least in relative control of the risks he is taking; danger is different in that it implies loss of control.

We are collectively learning how to manage this risk/danger equation. The "risk" here, if one can put it this way, is thinking of risk as a kind of acquired individual

[4] There is an interesting discussion on the subject in Professor Pires: pages 41 passim.

autonomy, and of danger as a limitation of this very autonomy by "the other", bringing about in its wake withdrawal, intolerance, and concisely, fear. For if risk is the source of intense pleasure, danger generally gives rise to fear. If risk points to the improvement of the means that allow me to be more in control of my safety, danger points to threats coming from the outside, chiefly from the 'other', over which I have little control.

Some concepts in medicine, and in science in general, add to this paradox when they address risk factors, such as when smoking is considered a risk factor for lung cancer. This is also the case with delinquency: dropping out of school is a risk factor as regards delinquency. Within these meanings, risk here becomes a danger factor, the ultimate danger, of course, being death (cancer). This mechanistic and causalist concept of prevention erases the fundamental difference between the body-machine we occupy and the body-subject we are, to use the distinctions proposed by Professor Malherbe. There is, in fact, no direct link between the "objective" characteristics of our environment (including the personal traits of genetic history, family and culture, etc.) and the subjective perception we have of ourselves and of our relationship with our environment. In other words, it is precisely why two children born in a similar environment, in the same era and friends from a very young age, will take two entirely different paths in life. We have a body with a genetic inheritance and pre-dispositions; what we do with it and how we interact with others and our environment is something else entirely. Just as there is no immediate transfer of the recognized fact to the norm, neither is there any direct translating my biopsychological make-up into actions and thoughts.

The scientific approach searching to identify a statistical "norm" – the correlation between two facts – does not take into account the fact that we are not all equal in the face of this risk/danger equation. What for some would constitute a risk – going down an icy mountain on skis – would represent a real danger for another.

> [Translation] *Despite all we think we know about addiction, a considerable number of well-informed subjects "happily continue committing suicide" through their dependencies. While health education is largely thwarted, and not only in the field of toxic substances, it is because human subjects are in fact subjects, that is to say "subjective" beings whose behavioural reactions are linked much more to the meaning they attach to their behaviours than to the objective mechanical-medical consequences which statistical analysis claims to define.*
> *Some risks are no doubt worth taking for life to be worth the trouble of being lived, for it not to dissolve into a maniacal and fearful sequence of endless precautions (…). Lastly, what is most human (the most autonomy, we dare wonder): succumbing to fearful hypochondria and enclosing oneself in a cocoon of universal prevention (to the point of death by asphyxiation and loss of will) or living one's life through risks freely chosen and accepted.* [5]

This is where the central position of the concept of autonomy comes in. Autonomy, however, is to be understood here in a critical manner as *reciprocal autonomy*,

[5] Malherbe, J.F. (2002) *op. cit.*, page 7.

and not as autonomy where isolated individuals establish standards to their own liking. It should be borne in mind that autonomy, etymologically speaking, means "establishing one's own laws". This is not a question of arbitrary legislation, created for oneself, but of laws that permit, whenever possible, the successful interaction with others, which is the very bedrock of society. This autonomy is based on the ability to recognize the existence, the difference, and the equivalence of the other, allowing one to assume solitude, finiteness and uncertainty, respectively, to then move on to practice solidarity, dignity and liberty in return.[6]

The "dependent" person is not autonomous, some would say. Indeed, in their dependency, the drug addict, the alcoholic and the inveterate smoker are not. Neither the emotionally dependent person nor the person addicted to gambling, money or sex is fully autonomous. Next comes the question of the extent to which the state or society can intervene to encourage the slow achievement of this autonomy, and how to go about it. What are the respective roles of collective governance and criminal law as mechanisms of this governance? How can science contribute to this emancipation?

In any case, we note Professor Malherbe's comment, that:

> [Translation] *(...) the fundamental problem of our civilization is not whether it is acceptable to prohibit the trade in cannabis derivatives or even their use, but rather not to repress the expression of anxiety when it arises and, even better, to invent new ways of taming it. On this point, it is useful to recall that every unjustified restriction, which adds to the already heavy burden of civilized individuals, can only increase their sense of being the object of some form of totalitarianism rather than the subject of their own destiny. From this standpoint, anti-drug campaigns seem decidedly like attempts to deny death rather than recognize its presence in collective and individual life. (...) In this respect, we agree with N. Bensaïd, who says that preventive medicine conceals our fear of death by making us die of fear.*[7]

From this base ensues a definition of ethics as "*constant work, to which we can consent and which we perform with one another in order to reduce, as far as possible, the inevitable difference between our values as practiced and our values as stated.*"[8] With one another, indeed, thereby imposing constraints so that reciprocity and equivalence of the 'other' can be realized; this is the role of governance.

As a guideline, we will adopt the principle that an ethical public policy on illegal drugs, and on cannabis in particular, must **promote reciprocal autonomy built through a constant exchange of dialogue within the community.**

---

[6] See Malherbe's discussion of the subject on pages 23-26.

[7] *Ibid.*, page 21.

[8] *Ibid.*, pages 27-28.

GOVERNANCE: MAXIMIZING THE ACTIONS OF INDIVIDUALS

We are social beings. It is a trivial assertion, however it must be stated because it means that, *necessarily*, we always find ourselves in paradoxical situations where to a certain degree, each person has the free will to make decisions, and makes free decisions for himself, while at the same time, in order to regulate interactions with others, rules are established, a normativity, that is more or less complex or more or less formal, as is appropriate. This is true of relationships between couples, families, in sports, and at work, as it is of relationships between citizens and the government. Self-governance – acquired through the arrival of liberal democracy – is never complete and inevitably yields in part to the governance of the community.

Governance is relatively easy to develop within simple relationships: within couples, families, or businesses. This is not to say that its practice is easy: anyone with any experience of relationships as a couple will be well aware of how difficult it can be to make implicit rules explicit, and to agree on the rules of a shared life. However, the standards that are established between friends, between lovers, between parents and children, are in fact a set of relatively simple rules, and most importantly, rules whose effectiveness does not require the intervention of other parties, except in the case of a break-up or of abuse.

In feudal, pre-modern or pre-democratic societies, the prevailing rules for even the simplest social relationships were stipulated from the outside: by the sovereign, the lord, the church representative, the father or forefather, the head of the business, each one could issue orders and expect to be obeyed, being all powerful in his domain. The establishment of normativity was largely done without the involvement of "subjects", without their consent, and without any input on their part; they were excluded from the power relationship. Over the centuries, during which our modern-day democracies were built, we have moved on to styles of governance of ourselves and others that allow people to participate more and more in the development of the rules of life, both personal and social. We have also moved on from a situation whereby each person's life was decided by his or her destiny, and limited to the narrow prospects dictated by the place of birth and status, to an "indeterminate" life situation, which is open to the building a personal identity and history.

These are therefore (1) changes in the sources of normativity and their operationalization in society, and (2) changes in our relationship to these norms. In the first case, we are slowly becoming involved in the external formalization of the sources of behavioural norms. As they no longer ensue from divine right, from the sovereign or the church prelate, they are built through the political manifestation of the will of the people. They are entrenched in national constitutions, in legal decisions (in British Common Law) or in legal codes (the Civil Code). It follows that the supra-legal normativity (inherited from divine right) or the infra-legal (not set out in law), lose both their symbolic value and their real influence on social relationships, to the benefit of legal rules that are registered according to a recognized and legitimate procedure in the

social system by means of statutory provisions. Modern societies are legal societies, that is to say societies that base their management of relationships between people and between individuals, groups and institutions, on the rule of law. Never completely incorporated into the legal system, other sources of normativity have not disappeared completely but the pre-legal or infra-legal sources of normativity are less apparent, and sometimes less legitimate.

With this change of source comes a change in operation: while the sovereign or the church representative could convict, or even execute, without challenge to the legitimacy or rationality of their decision – except by risking the same fate – the means of expressing the will of the people, setting it out in the legal system, is now in the hands of judges and the legal system entirely. The legal establishment of norms is set in motion either by the public authority provided in the legislation (civil and criminal cases, for example) or by citizens themselves (private and civil lawsuits) and is put in effect primarily by the courts. Remedies exist, and most importantly, these remedies are theoretically the same for, and accessible to, one and all.

The relationship that a person has to the norms, and through this to all aspects of social life, is the third change. Choice and uncertainty have both increased, to the point that, today, the connection is not so much to the other person, but to the risk represented by being in contact with them. Normativity in and of itself is no longer considered inevitable, nor even a duty. Without being rejected, social normativity is called into question based on personal experience and worldview. The gap between the subject of the norm and the norm itself seems to be widening, while conflict resolution models are being made more formal.

Through the conjunction of these processes, governance becomes more and more instrumental. The mechanisms of formal normativity, i.e. lawyers, judges and the courts, sometimes take on a greater importance than the actual substance of the norms themselves: the immediate personal question is whether I have access to the recognized mechanisms of conflict resolution, or if, through my condition or my actions, I am excluded in one way or another. In other words, the means is replacing the end, the rule of law is replacing the requirement for a connection to the other, which is the very basis of normativity and of social life itself.

Modern societies are therefore faced with a series of sometimes paradoxical injunctions. Collective governance must: (1) allow social relationships to be regulated in the most orderly but least restrictive manner possible, (2) give expression to the norms and values shared by the community and (3) give each person the opportunity to define themselves in relationship to these norms and values. How can these seemingly obvious opposites be reconciled?

Based on Professor Taylor's work[9], we can say that there are two central spheres or preferred means of governance: the governance of relationships with others, and the governance of the self. The governance of collective relations is obviously part of the

[9] Among others: Taylor, C., (1989) *Les sources du moi.* Montréal: Boréal..

traditionally recognized areas of intervention of the state, even if the form and substance change. On the other hand, governance of the self does not come immediately or systematically under the jurisdiction of the state.

Collective governance

The state is far from the only source of normativity. But the fact that democratic states must act in accordance with the law and that most public policies come in the form of legislative texts, produces a kind of short-circuit whereby the source of law and the state appear as one.

Yet, as Professor MacDonald rightly points out, if the actions of the state are subject to the rule of law, the legal sphere is not limited to the State. In all known societies, rules have always been established for the governance of the self and of collective relations. They are implicit or explicit, formal or informal, all-encompassing or limited in their application, codified or recorded in the collective memory, extensive or limited to certain spheres of activity. In every case, whatever the nature or specific form of the rules, they serve to express for members of the community the conditions of collective life. They deal with marriage and parenthood, the ways in which one respects the life and property of others, as well as the connections to the invisible and the beyond. They take the form of prescriptions and bans, are implemented by the bishop or the mullah, by the king or his representative, or by the judge. Much as we might like to believe, we in modern times have not invented the codification of laws because the first legal code goes back to Hammurabi, the King of Babylon. In Roman law, Justinien was the first to suggest a code of laws, not to mention the Ten Commandments "handed down" to Moses.

In this sense, we agree with Professor MacDonald as concerns legal pluralism, according to which there are multiple sources of normativity and therefore of rules of action that are not exhausted by formal legislation. This is the distinction between law and "juridicity". As we mentioned above, juridicity can be derived as much from the family as from business, from school as from the trade union, from political parties as from religion. In this sense, juridicity "is the business of subjecting action to rules-based governance".[10]

Juridicity, of course, co-exists with other ways of governing individual and community actions: the brute exercise of power and war are examples of other forms. One of the main differences, however, between juridicity and other forms comes from the nature and the origin of its legitimacy. The establishment of legal rules of action involves a form of consent, if not of active participation, in the development and implementation of the rule, qualities that are not needed nor sought out in the case of domination by a tyrant or an occupying army.

[10] MacDonald, *op. cit.*, page 24 of the English version.

The development of a formal juridicity, in the form of legal texts passed by legislative assemblies prescribing both objective and subjective rights, is at the very heart of modernity. It is in fact around these kinds of issues that the more specific question of the role of the State arises: when and to what extent should formal legal rules be developed, and how should they be enforced?

Modern societies are unique in that they have, amongst other things, given precedence to the formal rule of law over other sources of juridicity as regards the governance of social relationships, established the need for these formal laws to be adopted and implemented by legislative and executive arms of the State, and set up arbitration systems in the form of courts of law born of the State but having an arm's length relationship with the former two.

This formality of the law, or to be more precise, the legal normativity found in the legislative texts passed by the State, in no way signifies the disappearance of the other forms of normativity. Here Professor MacDonald gives us a relevant example of this:

> *For example, activity that the official criminal law sanctions and stigmatizes may be rewarded and valued in certain other normative communities. In socio-economically impoverished neighbourhoods where economic opportunities are limited, the manufacture and sale of illicit drugs may be an attractive means of escaping poverty. For those who are successful in the enterprise, the consequent advancement in social standing may more than offset the potential harms visited by criminal sanctions. Similarly, in an international context, in countries where the raising of traditional crops which are capable of being converted into illicit drugs is an indigenous cultural activity, and where conditions of poverty are such that the attendant economic benefits are necessary for subsistence, the criminal law (whether domestic or international) has little purchase.* [11]

In other words, juridicity is not exhausted in the formal law, and the role of the State is not limited to the processes of passing, enforcing and arbitrating formal legislation.

Governance of the self

Historically, juridicity has often been equated with moral standards, or has tried to model itself on them. These standards could come from religion, from philosophy, from an ethic, or a universal theory of nature as in Plato. In every case, they tried to say what constituted the "good life", how to conform one's life with the immanent rules of life, ending the cycle of reincarnations, or avoiding eternal damnation. In every case as well, the good life corresponded more or less to "life" in the most abstract sense, that is to say the focus was not so much on the destiny of the individual, but on that of the community, the group, the clan.

It is only as of the second half of the second millennium, during what we refer to as the Age of Enlightenment, that individual life slowly began to register as a primary

---

[11] *Ibid.*, page 25.

concern in the governance of the community. This major change resulted in what Taylor calls "ordinary life", that of the "average sensual man", at the heart of which we find his connection to the world and his manner of connecting with it through the agency of family and work, being suddenly recognized. Having had no means by which to participate in the development of juridicity in general until then, the "citizen" acquired some legal authority and right to active participation (to simplify things, we could give as an example the right to vote), not only as a member of the community but as a whole and unique individual.

Up until that time, communities had a juridicity that was largely based on relationships with others, granting strong objective rights (the right to life: you shall not kill; the right to property: you shall not steal; etc.), with a weak cognitive component: while admitting that it continues (unfortunately one might add), to pose certain problems (take racial or sexual inequality) even throughout the twentieth century, - accepting respect for life as a universal norm has not met with great opposition. It is in this sense that we speak here, particularly following Pires' work discussed in the following section, of norms with weak cognitive components. These fundamental norms, which certain philosophers of law have said are natural laws, do not require a strong empirical justification. The same cannot be said of other norms concerning conduct such as homosexuality, abortion… or taking drugs. These norms are an issue of what we might call subjective rights that relate to individual behaviours that express personal choices achieved through a consensual exchange and thus being of little or less direct concern to the community. This is why we could say this is an issue of norms with a strong cognitive component: in order to be imposed as negative laws, that is to say as constraints or prohibitions, these standards need an exogenous justification drawn from the external knowledge of juridicity itself.

In this way, parallel to the process of legal formalization of the norms of governance in the community described in the preceding sub-section, the modern individual has acquired more and more room for governance of the self. This space is no longer, as in the past, entirely dictated by the determinations stemming from one's birth in a given place, in a given family, with given genetic "baggage". Except in some totalitarian regimes, neither is this space for the governance of the self entirely subjected to collective or religious rules. This space consists of a vast area of uncertainty that, in part, precisely explains why it is sometimes called "disenchantment with the world", or more prosaically "loss of sense" or "lack of values". In fact, we would say that neither comes into play, so much as a process of slow and hesitant reinvention of social life, in and through new ways of relating as individuals.

The role of governance

Governance is part of both the spheres of collective governance of the State and of governance of the self. If the State's chosen vehicle is formal law, the passing of legislation does not exhaust all the possibilities in terms of collective governance.

Moreover, governance of the self is the slow discovery – in the strong sense of the term - of the juridicity that underlies human action.

Professor MacDonald addresses the issue eloquently:

> *How ought law and legal institutions to be deployed to achieve the symbolic governance of human agency in a manner that facilitates the just achievement of individual and collective human purposes?*[12]

The issue brings us back to the purposes of community governance, which is to facilitate human relationships and self-realization, with a minimum of interference in such a way as to stimulate individuals' discovery of the source of normativity rather than having it dictated by an external body. It is not the responsibility of State governance to ensure either the health or the happiness of its citizens. It is, however, its duty to ensure that the rules that it enacts and the way in which they are carried out do the least possible harm to the individual's ability to develop his or her own moral code. Not a single morality, or at least a morality for everyone, as the majority position of the Le Dain report maintained, but a facilitation of access to morality for citizens, morality here being understood in the sense of the ethical discovery of fundamental laws regarding relationships with others, as Professor Malherbe pointed out.

Professor MacDonald proposes a definition of governance that is drawn from the work of the Law Reform Commission, which gives guidance: the goal of governance is freedom, and not control. It is a question of defining the goals of society through policies and action programs that are then implemented through systems and processes and upheld by actors, allowing for the encouragement and affirmation of human action. The law, vehicle of choice of governance, does not seek instrumental purposes of simple expressiveness of rules or limitations passed for and on behalf of citizens, but a reciprocal process of building social relationships through which people, citizens and governments, can constantly adjust their expectations in terms of behaviour.

We therefore accept as a guiding principle for governance that **all of the means the State has at its disposal must work towards facilitating human action, particularly the processes allowing for the building of arrangements between collective government and governance of the self.**

CRIMINAL LAW AND THE LIMITS OF PROHIBITION

During the course of this report, we will have plenty of opportunity to describe the degree to which criminal law is at the very heart of any discussion of illegal drugs. It has come to the point that debates between those we refer to as prohibitionists on the one hand, and liberalists on the other, have overshadowed all other considerations. The

12 MacDonald, *op. cit.*, page 78.

Italian sociologist Pareto (1848-1923), quoted by Professor Pires in his issues paper, said of human beings that even if we would like to believe that we are rational, we are above all argumentative beings, that is to say that we want "to give a logical aspect to behaviours that do not have the substance thereof."[13] In the context of the debate on cannabis, this sentiment takes on its fullest meaning: both sides hurling their arguments at the other, claiming they are recognized "truths".

Any discussion on the role and the place of criminal law as concerns illegal drugs, here being a question of cannabis, in effect poses questions regarding principles of the appropriateness of turning to criminal law. In general, both sides are quick to escape this stringent argument on the principles to turn to justifications. As is true of both sides, justification has nothing to do with the mechanism itself, being the criminal law, but with the target, being cannabis. The result is the litany of "proofs" of the effects of cannabis. For some, the effects are significant enough to "justify" turning to the criminal law, and to list the risks associated with the use of cannabis: addiction, learning difficulties, delinquency, and impaired driving. For others, these same risks are so minimal, or are already covered by other criminal legislation (driving under the influence), that they do not justify the use of the criminal law. Whatever the case may be, the debate is no longer in relation to the principles but on justification.

This reflection on the role of criminal legislation is specifically intended to bring us back to principles of the appropriateness of turning to criminal law. The central issue is to attempt to identify the criteria that will help us decide in what circumstances society can–or must–turn to criminal law. It must then be determined if these criteria justify the use of the criminal law in relation to cannabis.

Requirement for distinctions

Raising the question as to whether or not the use of criminal law as concerns cannabis is justified necessarily brings us back to a primary observation: the use of criminal law is not justified in all cases, but, in some cases, it must be. This observation is supported by three findings: (1) that most social relationships are regulated without the use of criminal law; (2) that certain behaviours are forcibly within the sphere of criminal law; and (3) that certain behaviours legislation has criminalized, at certain points in time, have since been excluded from this domain. The possibility of including or excluding human actions from the sphere of criminal legislation rests on the ability to make distinctions.

However, a significant difficulty arises as soon as this principle of distinction is accepted *in practice*, and not simply in theory. Once an act has been recognized as being a "crime", it becomes part of the body of what defines all offences: behaviours against society. According to the internal logic of criminal law, the only eligible distinction would *precede* the decision to incorporate a behaviour into the law or not. If the

---

[13] Quoted in Pires, A.P. (2002), *op. cit.* page 8.

behaviour at issue is one that goes against the common good, it is a crime. Otherwise, it would be an uncivilized act, perhaps even an immoral one, but certainly not a crime. Once such a decision is taken, the only remaining distinctions to make would be with respect to form: the kind of procedure to follow and the severity of the punishment according to the nature of the offence.

Everything is done as if there were no positive distinctions made within criminal law between offences, as if the distinction was made only from the outside, before making the act an offence. In fact, distinctions between types of offences do exist. These are the distinctions made by Professor Pires, between standard prohibited behaviours and "two-sided" prohibited behaviours. It is more usual to distinguish between "victimless" crimes and crimes "with victims", but this categorization is incorrect. On the one hand, under criminal law, the victim is all of society. There are certainly individual victims, but by some kind of extension, the harm has in fact been done to all of society. This would explain the principle of deterrence, in criminal legal theory: by punishing a guilty party, we try to dissuade all those who might be tempted to behave in the same way.

On the other hand, this categorization brings us back to a single aspect, the subject of the offence, losing view of the other processes by which criminal law distinguishes between different kinds of offences. In this way, another kind of distinction that is intrinsic to criminal law falls under the modes of justification. A decision to criminalize homicide does not require, as Professor Pires stresses, the undertaking of comparative studies in order to determine if one kind of murder is more or less harmful than another to the victim. The cognitive component is weak: here, there is no need to turn to external arguments to justify the criminalization. The act, in and of itself – this is the concept of *malum in se* – is enough to establish the legitimacy of the criminal standard. There is no such thing when the issue is drugs: since the beginning of prohibition, external justifications were needed regarding the harm caused by drug use. These subjects of criminalization have a strong cognitive component, in that they require a higher level of justification.

The distinction between kinds of prohibitive behaviours is therefore an analytical tool that is necessary in order to understand and think about the role of the criminal law as concerns drugs. What then are the criteria we can use in order to make these distinctions? This is the goal of the following sub-section.

Criteria for distinction

Professor Pires proposes seven criteria allowing for distinctions to be made between the various kinds of prohibitive behaviours in criminal law.

Seven criteria to distinguish between offences	
Nature of the offence	Is this an issue of a conflict or an exchange?
Capacity of the law for discernment	Can the law see a victim and distinguish them from the deviant?
Referentiality	Is the actor able to appreciate the consequences of his actions on another person?
Limitation on natural liberty	Is it possible that there could be limitation of the freedom of the person to act?
Justification of the offence	Must the law turn to outside knowledge in order to justify the enacted standard?
Application of the law	Does application of the law require any active intervention?
Effects of the law	Can the effects of applying of the law compromise the standard?

We will briefly examine these, one at a time.

The nature of the offence

In order for there to be an offence, harm must have been done, which brings us to the victim. As we said above, in the broadest sense, criminal law sees society as the ultimate victim of any offence. The direct victim of an assault or theft is a witness, in the technical sense of the law. However, at a concrete level, the law recognizes direct victims. In certain cases, the concept of victim falls somewhere between the two: it is the neighbourhood or the surrounding area, for example, in the case of nuisance caused by solicitation for the purposes of prostitution. However, these nuisance situations are themselves at the limit of criminal law, in a sort of gray area between standard offences and two-sided offences.

What is remarkable is that the criminal law cannot take all three levels into account at the same time. If it recognizes the direct victim, then society becomes invisible. If it considers the neighbourhood, it becomes even more evident that it can no longer recognize a direct victim or society as a whole. Finally, and above all, if it takes the perspective of society as a whole, then it loses sight of not only the direct victim, but what is more, it loses its specificity. In effect, in the latter case, one could say that civil law also protects society: without respect for sales contracts and debts, society would go down the drain.

It is therefore not only the harm caused, nor even the presence of a victim that gives certain acts their criminal character, but the fact that they bear witness to conflict, abuse of power, infringement of one social actor upon another. Obviously, civil law also serves to resolve conflicts, from which comes the need for more criteria.

Capacity of the law for discernment

Is the law able to differentiate a victim from a perpetrator? In the case of standard prohibited behaviours, it generally can. For example, the victim of a homicide can clearly be distinguished from the perpetrator. Of course, there are exceptions to these

standard scenarios, for example, where the victims themselves face criminal charges. A case in point would be where a victim of sexual assault is convicted of contempt of court for refusing to testify against her attacker.

When faced with two-sided prohibited behaviours, criminal law is hard-pressed to distinguish the victim from the perpetrator. Or, it finds the perpetrator to be the victim that must be protected from himself. Consequently the perpetrator becomes the victim of his/her own behaviour.

Alternatively, cognisant of the limitations and difficulty involved in punishing the victim - for example, a prostitute - criminal law shifts from the phenomenological world (the facts) to a different mode of reasoning. It moves from an analysis-based mode of reasoning (evidence enabling deduction) to one based on consequentialism or teleology (the goals underlying behaviour). For instance, criminal law justifies its intervention by the need to protect children. Consequently, it loses, and causes us to lose, sight of the (ultimately inexplicable) reasons why the offence was brought before the courts in the first place.

Referentiality

This term refers to the capacity of perpetrators of the offence to recognize – despite "explanations", denial or other self-justification methods - the harm caused to others by their actions. Even in case of some borderline standard prohibited behaviours, such as cruelty to animals, the perpetrator of the offence – who, for example, has hanged his neighbour's dog from a tree – may recognize the harm caused by his/her action to the animal's owner. The criminal act in the case of two-sided prohibited behaviours may be self-destructive, but is not motivated by maliciousness towards others, since it does not create a direct relationship with others. Indeed, the sociologist A. Ehrenberg raises the issue of the absence of a relationship with others exhibited in all types of drug use when interpreted as a form of withdrawal from the world. However, this is already beyond the issue of criminal law into to the realm of political discussion on democracy.

Limitation on natural liberty

We shall deal only briefly with this issue here since it is discussed at greater length later. Suffice it to say, however, that the law places special restrictions on what Kant called the "unfettered freedom of action": criminal law restricts an individual's liberty to take the life or property of others. Consequently, it institutes specific rights and freedoms, i.e. the right to enjoy life and property. Fundamental problems arise where the law seeks to restrict the very rights and freedoms that it provides. A case in point is prostitution, where the law seeks to restrict the very right to enjoy one's own body and the freedom provided for by the law.

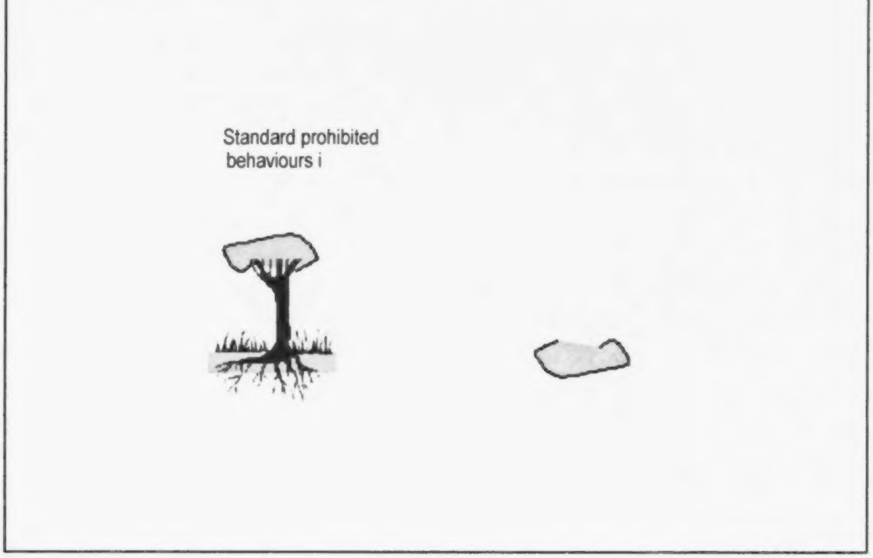
Justification of the offence

Criminal law very seldom uses external sources to justify the criminalization of offences. A good example to illustrate this is our original homicide scenario. Criminal law does not refer to sociology, anthropology, history, economics or medicine to establish the various effects of different types of homicides and various ways of taking life. The same rationale can be applied to sexual assaults, theft, fraud, etc. The cognitive component in the justification process is weak. The rationale underpinning the standard prohibited behaviour is deeply rooted in the social relationship. It is quite clear that any society even considering legalizing homicide would become untenable and would cease to be a society at all. Consequently, our society does not question the validity of the criminalization of homicide. The sole issue that arises in some countries, but which was addressed in Canada a long time ago, is the sentence society imposes on murderers.

Quite the opposite situation exists for two-sided prohibited behaviours. They require empirical demonstration and justification with a strong cognitive component. As one might expect, this issue is central to any debate on drugs. Indeed, this report accords a great deal of importance to this matter.

Below professor Pires deals with this issue in graph form.

Table 5: Illustration of the reversal of direction of the bases for criminalized prohibited behaviours



As professor Pires points out, the criterion here is not to establish whether there is consensus or "dissensus" on the criminal standard or on the terms relating to the type and possibility of democratic debate but rather to determine whether the source of the legitimacy of the standard is endogenous or exogenous. In the case of standard

prohibited behaviours, the source is endogenous. In the case of two-sided prohibited behaviours, it is exogenous. However, the criminal law creation process remains the same, i.e. democratic debate resulting in the adoption of enabling legislation. It is for this reason that it is all too easy to lose sight of the fact that the two types of offences are not in fact of the same nature.

> [Translation] *The important point to remember is that all two-sided prohibited behaviours to which this criterion applies exhibit certain specific problems. (i) They all have a more precarious, more ideological or more fragile endogenous basis because they are not rooted in a concrete, conflictual deviance and because the norms are not sufficiently detached from certain forms of (purely moral or religious) knowledge or are not sufficiently unaffected by knowledge of facts. (ii) They are therefore more subject to a process of selection from the available knowledge and to the actual value of the knowledge that we select or that is available to us in respect of them at a particular point in time. That means that a critical and serious examination of the knowledge is of crucial importance. (iii) They are, to all intents and purposes, more polemical and subject to public debate at a particular point in time, and more likely to be based on major cultural or cognitive misapprehensions.* [14]

Application of the law

In the vast majority of cases involving standard prohibited behaviours, offences are brought to the attention of the police by way of a complaint. Complaints to the police most often involve theft, sexual assault and homicide. Indeed, approximately 90% all offences that come to the attention of the police do so through complaints. In the case of two-sided prohibited behaviours, close to 100% of offences are discovered pro-actively.

One might point to the increase in complaints from people living near cannabis plantations in British Columbia. However, these people's complaints perhaps deal either with the very real danger of fire – since the illegal nature of cannabis production forces producers to illegally tap into electricity lines – or with pressure on them from criminals to keep quiet – also because producers are forced to operate illegally.

The pro-active application of the criminal law in the case of two-sided prohibited behaviours has harmful consequences, including social and human costs but also the possibility of discriminatory application of the law or police corruption. This raises the question of whether the endogenous basis of the offence warrants these consequences.

Effects of the law

The effects of the law stem, to a certain extent, from the previous criterion and all the others before it. This criterion relates to the legitimacy of the standard. The difficulties and criticism arising from pro-active police action, changes in social normativity or in the knowledge base, make the law counter-productive, which, in turn, raises questions *sui generis* as to its basic tenets and legitimacy.

---

[14] Pires, A.P., (2002) *op. cit.*, page 59.

We have compiled Professor Pires' suggested criteria under three headings. Each criterion includes an "action-related" and a "law-related" element, which can be used in distinguishing between various criminal offences.

Nature of the offence. The action here refers to the relationship between the "victim" and the "perpetrator", i.e. are they in a conflict or exchange-type situation? The law-related criterion focuses on establishing whether criminal law is able to distinguish between the victim and the perpetrator.

Justification. The action in this case is to determine whether perpetrators are able to recognize the harm caused to others by their actions. The legal aspect of the equation deals with determining the basis of the legitimacy of the standard.

Operativity. The action relates to identifying whether the application of the appropriate standard is triggered by the victim or witness or whether pro-active action is required by law-enforcement agencies. The legal side of the equation is to establish whether the enforcement of the standard could potentially sabotage itself.

It is our view that the analysis of *Criminal Code* offences based on these three criteria addresses the fundamental issue of whether limiting the liberty of an individual to act is justified in the criminal law. It is for this reason that we are less concerned about the criteria themselves than about the result of the application of theses criteria to the criminal law standard.

Application to illegal drugs issues

Are illegal-drug-related offences two-sided prohibited behaviours under criminal law? Undoubtedly so.

The offence created implies an exchange-type situation and it is relatively unimportant whether the subject of the transaction is a prohibited substance or not. It is deemed to be a consented exchange between two parties. In the case of cannabis use – or the personal use of the opium or cocaine that just happens to be growing in my garden, - no exchange with another party takes place. Nevertheless, possession is prohibited in Canada, as is use in certain other countries.

Criminal law is hard pressed to find a victim. With respect to impaired driving endangering the lives of others, the *Criminal Code* contains a provision for the punishment of an individual operating a vehicle under the influence of any substance. The argument that cannabis poses enforcement difficulties is not valid. The same difficulties apply to driving under the influence of prescription drugs. What about the issue of children? It is difficult to see how cannabis use harms children, except where an "uncontrolled" market, brought about either by a lack of regulations or by the current illegality of cannabis fostering illegal markets, does cause harm to children.

In relation to referentiality, a user or even a seller does not see himself or herself as causing harm to others. At least, this is the case for cannabis derivatives. Of course, a situation where "grass" is mixed with other substances and adulterated substances are sold to users is reminiscent of the era of prohibition and is one of the reasons why

prohibition was scrapped. To justify behavioural standards and the offence, criminal law has to refer to external sources over which – and the interpretation of which – it exerts no control.

The operativity of the standard raises both application problems and on-going questions as to the legitimacy of the standard itself.

On the whole, the legal basis of the criminal law is weak where the prescribed standard (1) does not concern a relationship with others and where the characteristics of the relationship do not create a victim and a perpetrator able to recognize his/her actions; (2) has to find its justification outside fundamental social relationships; and (3) results in a form of enforcement, the harmful effects of which, undermine and challenge the very legitimacy of the law. (Where criminal law is involved in these issues, the very standard prescribed by the law makes the perpetrator the victim and tries to protect him from himself, which it can do only by producing a never-ending stream of knowledge, which remains constantly out of his reach.)

This analysis indicates to us that **only offences involving significant direct danger to others should be matters of criminal law**.

SCIENCE OR APPROXIMATE KNOWLEDGE

> *The public is generally willing to leave the choice of control methods to the interaction between health care experts and government agencies because they recognize that the drug is being used essentially for their well-being and they rely on expert knowledge to decide the best way to protect that.*
>
> *(...)*
>
> *Therefore, in formulating social policy on non-medical use, you must consider not only at the harm done by the law or at the harm done by the drug, but as far as possible a full cost/benefit analysis of drug use and the control measures, and any change in control measures that you may contemplate. This is a matter for all of society to decide - not for experts to decide as a matter of scientific knowledge.* [15]

From the very outset of the Committee's proceedings, we have been aware that knowledge - even science-based, is not of itself a sufficient basis for the development of public policy on illegal drugs, in particular cannabis. One might be tempted to think that a Special Committee on Illegal Drugs - in this case, cannabis - should base its conclusions and recommendations solely on knowledge. However, no amount of knowledge alone could determine public policy. There are several reasons for this.

Firstly, the process of knowledge development is ongoing. This process is by definition a continuing study of the unknown. The pursuit of knowledge, in view of the scale and complexity of the task, is always approximate - or, as the French

[15] Evidence by Dr. Harold Kalant, professor at the University of Toronto, before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, issue no 4, pages 69 and 78.

anthropologist Claude Lévi-Strauss would have put it, cobbled-together. To search for knowledge is to acknowledge our ignorance of fundamental questions, which by definition remain open-ended. According to Professor de Koninck:

> [Translation] *It is appropriate for us to celebrate the ignorance we have at last discovered because it is now part of our known ignorance (ordinary ignorance, in the classical vocabulary), as opposed to unknown ignorance (twofold ignorance) - thanks to neuroscience, oceanography, astrophysics, but also to depth psychology, the history of religion (to cite only two of the advanced "humanities") and to other disciplines which have particularly progressed in our era. We must celebrate it with the wonder and puzzlement which are still the necessary prerequisite of all discovery.* [16]

This situation might seem ironic, since never at any other time has such a wealth of information been produced – in all areas of human culture but also specifically on the issue of drugs – than in the modern era. So much knowledge has been gained in fact, that experts, such as economists, sociologists, criminologists, psychologists, and geneticists have become necessary players in the whole public policy justification process. It is only thanks to the ability of a team of scientists to successfully influence decision-makers that the greenhouse effect and the global warming phenomena have been acknowledged as real and that action has been taken to protect our environment. Governments' macro-economic decisions will be explained to the public on the nightly news by a senior economist. Where urban violence occurs or a serial killer is on the rampage, psychologists and criminologists are brought in to explain what is taking place, or to justify the thrust of criminal policy. The mass production of information and reference to experts in policy development give the public decision-making process at least credibility, if not legitimacy. Consequently, people who feel disenfranchized or even disillusioned by what they perceive as the disparity between the real world and the world presented to them in the media, will feel less inclined to challenge political decisions which are based on the "authority of knowledge". Information is becoming knowledge, the learned are becoming experts and politicians, (who are increasingly allergic to independent reflection on principles and fundamental issues), have come to rely on this handy army of "experts", who are ever ready to proffer advice.

However, information is not knowledge. Indeed, knowledge cannot be reduced to mere information. The Internet teams with information, but no one would dare contend that all of it could be deemed knowledge.

Secondly, the knowledge production process is fragmented and, like modern life itself, has difficulty addressing the issue of meaning. No better knowledge is produced with the addition of academic disciplines all studying issues through the lens of their own field of expertise than is produced when one of these disciplines works in isolation. The promotion of inter-disciplinary and trans-disciplinary approaches will remain as meaningless as calls for a social "partnership", until there is genuine resolve to grasp the issues of meaning and comprehension. Prestigious institutes such as NIDA

---

[16] De Koninck, T., (2002) *op. cit.*, page 25.

may have huge research budgets and conduct research, which in itself, is both fascinating and useful, but they function as if their sole goal were to demonstrate the bio-psychological mechanisms of "drug addiction" and the dangerous abuse that results from the consumption of "drugs of abuse", as they call them.

However, the reasons for particular practices cannot be reduced to the sum of their constituent parts, or a jumble of re-enactments. Remarkable knowledge about cell mechanisms and genetics does not provide answers to the ethical and political issues raised by cloning. In the same way, knowledge about the mechanisms of the atom and nuclear fission did not provide answers to the issue of the manufacture and use of nuclear weapons. The highly abstract and math-based discipline of economic "science" is so far removed from reality that it is no longer able to explain the gulf that exists between nations or between extravagant wealth and human misery.

Researchers seem more concerned with mathematical equations and abstractions, and as a result, fail to ask fundamental questions. Their fields of knowledge are patchy and highly compartmentalized and there often remains a confusion between knowledge, information and technology. To ask fundamental questions, is to link issues and to re-acknowledge the complex nature of these issues in an attempt to identify the underlying reasons. There are on-going debates between scientists and philosophers over linking issues and over the shift towards an integrated knowledge base of human beings.[17]

Thirdly, this raises the whole issue of the so-called "learned idiot" "experts".

> [Translation] Idiots *is the right word (from the Latin* idiota, *meaning "ignorant person", borrowed from the Greek* idiôtês, *of the same meaning, as opposed to* pepaideumenos, *"cultivated man"). What is unfortunate is that their unearned reputation as experts extends all the more the influence of this "idiocy" in societies such as ours where "science" exercises a magic power and "that power appears increasingly legitimized by 'learned' experts," as Jacques Testart notes. "Indeed, the expert provides reassurances and citizens are reluctant to decry the absurdity or cynicism of a political decision approved by 'the most qualified experts'.*[18]

We are not trying to take issue with science but rather to challenge the difficulty scientists have in reflecting on their research. It is one thing to conduct cutting-edge research on specific issues, but it is quite another to claim to use the resultant fragmented knowledge to provide "explanations". It is yet another to attempt to provide answers that science is quite simply not able to provide. It is one thing to conduct studies of the behaviour of laboratory rats, which have been administered a dose of Delta 9-THC (the principal active component in cannabis), but it is quite

[17] Based on a very eloquent exchange between a philosopher and a neurobiologist: Changeux, J.P. et P. Ricoeur (1998) *What makes us Think* (translation of: *Ce qui nous fait penser. La nature et la règle.* Paris: Odile Jacob), pages 77-78

[18] De Koninck, T. (2002) *op. cit.*, page 6.

another to claim that this type of experiment is useful in understanding cannabis use and its effects on human beings. It is still another issue to contend that this research can provide an answer to cannabis public policy-related issues.

Drug use is a social action and forms part of a particular individual's behavioural pattern and as such, cannot be reduced to mere neuro-psychological mechanisms. It might be useful to understand the mechanisms involved but this knowledge alone will not explain the reasons underlying drug use in our society.

Fourthly, the colonization of the mind by the authority of experts-acting as mediators between politicians and the community – equates to the dangerous colonization of social sciences by natural sciences. This is nothing new. This process began in the 19th century but significantly accelerated during the 20th century. The most significant manifestation of this process is the ever-closer links between psychology and neuro-science. Consequently, a transposition of methods and problem-approach systems has taken place. As a result, human sciences have now taken on a quantitivist-reductionist approach, which in turn has led to a knowledge crisis. A sample of 100 young people chosen at random to undergo a battery of psychological tests aimed at determining why they use cannabis will provide apparently serious anecdotal research and a series of correlations, which are unlikely to reveal the reasons behind drug use.

In some academic and decision-making circles, it is fashionable to refer to "*evidence-based*" policies. By this, we mean policies based on "scientific" evidence of approaches that work. One of the most striking examples of this approach was the Crime Reduction Strategy implemented in the United Kingdom in 1998 by the then newly-elected Labour government. Under this scheme, considerable money was earmarked to support those crime prevention initiatives that studies had shown to be effective with the goal of reducing various types of crime by a specified percentage over a five-year period.[19] Despite this scheme, the United Kingdom is currently facing a crime "crisis", in part because crime rates have risen, and the Crime Reduction Strategy is a shambles.

It is tempting to ask how the outcome could have been any different. Social engineering strategies in areas such as population control and crime prevention date back to the 19th century and have rarely provided tangible results. These initiatives, which are built on one or two "formulae", themselves drawn from a small number of controlled experiments, do not take account of the complex nature of the modern world, with its ever-growing, increasingly fluid and intangible interdependent and multi-level relationships. Is it in an attempt to flee this reality that we seek refuge in the mathematical abstraction of correlations between supposedly predictive variables?

The Committee' report - especially the second part - has put great emphasis on research-based knowledge. This focus is an attempt to do justice to the knowledge that

[19] Chapter 20 discusses this issue in greater detail since the strategy includes a drug-related initiative.

has been developed over the past few decades. We considered it important and indeed necessary to give it detailed consideration. Indeed, the Committee recommends that the drive for knowledge acquisition on specific issues that we deem to be important be continued.

We do not claim, however, to have answered the fundamental question of why people consume psychoactive substances, such as alcohol, drugs or medication. We were indeed surprised, given the quantity of studies conducted each year on drugs, that this area has not been covered. It is almost as if the quest for answers to technical questions has caused science to lose sight of the basic issue!

Scientific knowledge cannot replace either reflection or the political decision-making process. It supports the process. Indeed, we consider that its greatest contribution to public drug policy is in doing so. Our guiding principle is that **science, which must continue to explore specific areas of key issues and reflect on overarching questions, supports the public policy-development process**. No more, but no less.

CONCLUSIONS

One of the greatest challenges for modern societies is to collectively invent new forms of social life and community belonging that stretch beyond the tools of formal law. As individuals with objective and subjective rights, people can participate fully in the development – we would even go as far as to say the conquest – of the collective project of creating a society. It is no longer sufficient just to develop legislation and for people to automatically accept this legislation just because it was democratically decided by Parliament. We need to promote ethical participation - through discussion - in the development of collective and individual governance. The groups from civil society, whether they oppose the "behind-closed-doors" globalization process or support promoting fair and sustainable development, are asking how we can collectively develop a joint-participation normativity process, in which collective governance and individual governance are mutually supportive.

This discussion brings us to the conclusion that **public policy on illegal drugs, specifically cannabis, ought to be based on an ethic of reciprocal autonomy and a resolve to foster human action. It ought to defer to criminal law only where the behaviour involved poses a significant direct danger to others. It ought to promote the development of knowledge conducive to guiding and fostering reflection and action.**

CHAPTER 4

A CHANGING CONTEXT

Our work is being conducted at a time in history, in a given historical period. That history is not simply a field external to us, something outside us, exercising no influence on what we do. It is closely bound up with our actions, influencing them in various subtle ways. At the same time, because we are living through and making that history, we do not have the necessary distance from it to reconstitute all its elements or to understand all its implications. However, to re-situate our work in its complexity and uncertainty, we have a responsibility to attempt to ascertain certain elements of this history-in-the-making. This brief chapter is an attempt to identify certain historical elements we think are relevant to our effort. We have identified six elements which we have divided into two spheres, international and national, recognizing that those two spheres necessarily interact with each other. The international elements are: the globalization of markets and the trend toward economic and even political integration; the spiralling increase in discourse on safety and the drug-crime equation; and the aspects of change becoming apparent in certain countries with regard to drug policies. The national elements are judicial activism, which is reflected in significant court decisions at least with regard to the therapeutic use of cannabis; the adoption of the National Strategy on Community Safety and Crime Prevention; and the fight against organized crime.

CHANGES IN THE INTERNATIONAL SPHERE

The last two decades have witnessed significant changes in the international arena and in the structure of national states. The idea here is not to write the history of or to analyze this period. A few of those changes, however, have had a definite impact on drugs.

Globalization and integration

Since the early 1980s, with market deregulation, we have witnessed a globalization of trade and a more significant degree of continental integration. The end of the Cold

War and the disappearance of the Soviet Bloc, as well as the opening of China to capitalist markets, have merely increased the pace of these movements. As a result, we have seen, in particular, an increasing degree of integration of the European economy under the Maastricht accords and in the North American Free Trade Agreement between Canada, the United States and Mexico.

At the same time, rapid technological change, particularly through the Internet and satellite communications, has helped to further open borders, although in varying ways and to various degrees, depending on the level of development in the various countries, to the movement of goods and capital. Similarly, the increase in population flows and travel has led, at times by default or even against the will of certain states, to freer movement of people.

These changes have had a significant impact on the illegal drug markets. The opening of markets and borders has of course created new money laundering opportunities, while making it more difficult to monitor borders and transportation. However, we all too often forget certain effects of macro-economic policies governing global capital flows and expected structural adjustments, particularly in developing countries. One study produced for the United Nations International Drug Control Program clearly shows this.

> *Efforts to achieve (balance of payments) stability often aim to reduce the external deficit by reducing the level of domestic consumption. Macroeconomic stabilization often requires a reduction in expenditure by government and/or the private sector.*
> *In situations of reduced money growth, an infusion of hard currency can bolster a country's foreign reserves, ease the hardship associated with expenditure-related policies, and moderate foreign indebtedness. Drug money could in this light be perceived as a potentially stabilizing force, a source of capital without the strings of conditionality attached. Clearly, there are "benefits" which accrue to countries which serve as reservoirs of the revenues from the international drug trade.* [1]

In addition, the trend toward the privatization of entire sectors of national economies, particularly in Eastern European countries after the fall of the Berlin Wall, but also in a number of Latin American and Asian countries, in an environment in which internal regulation measures are weak and bank credit tight, fosters the inflow of money from organized crime particularly through the laundering of drug money. It has been observed moreover that the concentration of industrial production in those countries is not necessarily reduced following privatization, thus further favouring penetration by organized crime.[2]

Observers also too often forget the role of investors from the developed countries, where the push for deregulation and market liberalization originates. In those countries, as Campodònico has noted, "*(r)are indeed are prosecutions against drug traffickers or*

---

[1] Keh, D.I. (1996) *Drug Money in a Changing World. Economic Reform and Criminal Finance.* Vienna: UNDCP, technical paper no. 4.
[2] *Ibid.*, pages 11-13.

financial institutions of the industrialized world, which is precisely where most of the proceeds of drug trafficking are kept."[3] The result is a kind of dual discourse in which the necessity of liberalization of capital for multinationals makes it impossible to distinguish between clean and dirty money. The example of Peru developed by Campodònico and that of Russia examined by Keh show striking structural similarities.

The end of the Cold War also meant that the countries allied to the Soviet Bloc, or internal guerrilla groups, had to turn to other sources of financing. This is the analysis of the Geopolitical Drug Watch and its founder Alain Labrousse, who appeared before the Committee on May 28, 2001, citing the example of Kosovo:

> *What happened in Kosovo is a good example in this regard. The creation of the KLA was financed by intense heroin traffic from Istanbul. The heroin was sold in Switzerland to buy Kalashnikovs and handguns. They were more or less freely available and were stored in the Albanian part of Macedonia.* [4]

And as though to make the connection with the perverse effects of liberalization and the involvement of macroeconomics, Mr. Labrousse wrote in an earlier book:

> [Translation] *According to estimates, drug trafficking in the world generates between 420 and 577 billion francs in business annually. The growing role that these funds play in the democratization and economic restructuring process is leading to an explosion in drug production and trafficking in Asia, Africa and the East. It is this windfall, drawn on by local powers of all kinds, that fuels nationalist, ethnic and religious conflicts in the Third World and countries of the former Communist Bloc. Drugs, an economic issue and a tool of power, are now a given in international relations. Apart from a few major traffickers, the banking systems of the rich countries, the IMF and the major international organizations are involved.* [5]

Like other analysts, Mr. Labrousse observes that the developed countries are not immune to criticism since they "close their eyes" when their interests, particularly strategic and economic, are at stake.

> [Translation] *An incident occurred and was reported by the press when the international financial action group prepared a list of countries suspected of engaging in money laundering; it did not include either the Anglo-Norman island of Jersey or the Principality of Monaco, which surprised everyone. It was subsequently discovered that France and England had negotiated with each other to ensure neither appeared on the relatively infamous list.* [6]

---

[3] Campodònico, H. (1996) "Drug trafficking, laundering and neo-liberal economics: Perverse effects for a developing country." in Dorn, N. *et al.* (eds) *European Drug Policies and Enforcement*. London: Macmillan Press, page 231.
[4] Senate of Canada (2001) Proceedings of the Special Committee on Illegal Drugs, Ottawa: Senate of Canada, Issue No. 3, page 27. The reports of the OGD may also be consulted at: www.ogd.fr.
[5] Labrousse A. and A. Wallon (1993) *La Planète des drogues: organisations criminelles, guerres et blanchiment*. Paris: Seuil.
[6] Labrousse, *op. cit.*, pages 28-29.

This is also the case of European interests in Morocco and Africa more generally, as well as American interests elsewhere, in tax havens.

Chapter 1 of the 2001 report of the International Narcotics Control Board (INCB), a UN agency responsible for monitoring implementation of international drug control treaties, concerns the effects of globalization and new technologies. The agency writes that, apart from their "innumerable benefits" globalization and new technologies have had perverse effects: undermined cultural identities, political and social itemization, marginalization and growing poverty in certain sectors. According to the Board, "*these disparities are exploited by drug dealers and traffickers in their attempts to develop new markets. Moreover, in the course of the last decade, the growth in trade and financial activity has provided criminals with greater possibilities for concealing the illicit transfer of goods such as internationally controlled drugs and precursor chemicals and for disguising the proceedings therefrom.*"[7] According to the report, drug traffickers use new technologies to enhance the effectiveness of product delivery and distribution, to protect themselves and their illegal activities and to commit conventional offences using new methods or to commit new types of offences.[8] Among other things, the Board also notes:

- The Inter-American Drug Abuse Control Commission noted for 1999-2000 that the Internet had become the most widely used medium for expanding the production of synthetic drugs in some countries of that region;
- According to the International Criminal Police Organization (Interpol), in 2000, over 1,000 Web sites world-wide offered to sell illicit drugs, mostly cannabis;
- Increasing recourse to electronic means of financial transfer, together with a massive growth in the volume and speed of monetary flows, lead to reduced capability for detecting illicit capital movements; and
- The Financial Action Task Force on Money Laundering (FATF) has warned that there are three characteristics of Internet use that could aggravate certain conventional money-laundering risks: ease of access, depersonalization of contact and rapidity of electronic transactions.[9]

In short, while the search for greater coherence, and indeed for better predictability of international markets, is highly promising, particularly as regards the developing countries, it also has untoward effects, regardless of all other geopolitical considerations. Moreover, these characteristics also afford "unexpected" benefits… for organized criminal groups.

---

[7] *Report of the International Narcotics Control Board for 2001*. Vienna: author, page 1.

[8] *Ibid.*, page 2.

[9] *Ibid.*, pages 2-4.

Difficulties of the security debate

Over the same period, in various Western countries, a preoccupation for domestic security has gradually arisen in response to the perceived or actual increase in crime and to the public's feelings of insecurity. The effects of this have been observed in election campaigns based on law and order and in a shift toward measures considered repressive by some, such as zero-tolerance policies.[10]

With regard to drugs, this social discourse has had two main components. The first, starting in the early 1980s under Ronald Reagan's presidency, was the "war on drugs", which went far beyond U.S. borders. The second, starting in the late 1980s, an attitude increasingly emerged that equated drugs with crime.

The war on drugs made it possible to allocate unprecedented resources to the effort. It was at this time, it will be remembered, that Canada launched the first phase of its anti-drug strategy with a budget of $210 million over five years. In its "war on drugs" the United States allocated 17 times that amount, increasing federal spending alone from $100 million in the early 1970s to more than $17 billion in 2002. The combined spending of the federal government and the states on the war against drugs was estimated at more than $40 billion in 2002.[11] As a result, that war led to a quadrupling of the American prison population, from 500,000 inmates in the early 1980s to more than two million in the late 1990s.

> *During the 1990s, corrections constituted one of the fastest growing line items in state budgets. On average, corrections consumed 7 percent of state budgets in 2000. Today, it is costing states, counties and the federal government nearly $40 billion to imprison approximately two million state and local inmates, up from $5 billion in combined prison and jail expenditures in 1978. Twenty-four billion of that was spent on the incarceration of non-violent offenders. Despite the modest recent decline in state prison populations, the massive growth in state prisoners over the past two decades has meant that* **one out of every 14 general fund dollars spent in 2000 was spent on prisons.** *(…) The expansion of America's prisons has been largely driven by the incarceration of non-violent offenders. The percentage of violent offenders held in state prisons declined from 57 percent in 1978 to 48 percent in 1999. From 1980 to 1997, the number of violent offenders committed to state prison nearly doubled (up 82 percent), the number of non-violent offenders tripled (up 207 percent) while the number of drug offenders increased 11-fold (up 1040 percent).*[12]

In Canada, as will be seen in Chapter 14, while the overall crime rate has been declining regularly in the past 10 years, the percentage of drug-related incidents has constantly increased, and the overall prison population has remained stable. There are

[10] On this point, see, for example, the work of Wacquant, L. (2000) Les prisons de la misère. Paris.

[11] McNamara, J.D. (2000) "Commentary: Criminalization of Drug Use." *Psychiatric Times*, Vol. XVII, No. 9.

[12] Greene, J. and V. Schiraldi (2002) *Cutting Correctly: New Prison Policies for Times of Fiscal Crisis.* Washington, D.C.: The Justice Policy Institute. See also Schiraldi, V., Holman, B. and P. Beatty (2000) *Poor Prescription: The Costs of Imprisoning Drug Offenders in the United States.* Washington, D.C.: Justice Policy Institute. Available on line at: www.cjcj.org.

even grounds to suggest that the percentage of inmates with addiction-related problems has in fact risen.

This discourse has resulted in a host of national and international measures, in particular increased policing powers in the war against drugs in various countries, a reinforced international police infrastructure, use of the war against drugs in international diplomacy and its reflection in UN proceedings, particularly at the United Nations' extraordinary session on drugs in 1998.

The other aspect of the debate is the drug-crime equation. For a significant proportion of citizens, drug use is associated with crime, when it is not simply reduced to one of its major causes. Witness the following comments:

> *We cannot continue to apply policies and programs that do not deal with the root causes of substance abuse and attendant crime.* [13]

> *In countries that have adopted permissive policies toward drug use, violent crime and organized criminal activity have increased proportionately to the drug trade.* [14]

> *The social harm from other illicit drugs (such as cannabis - ed.) presents a different picture. In some communities or neighbourhoods across the country, the harm caused to innocent victims of violent crime and property crime is very great. (...) This results from drug-addicted users committing crimes to get money to feed their habit.* [15]

Deeply rooted in perceptions and attitudes, this belief, which is discussed later in Chapter 6, and which research data support only in part, has resulted in a series of measures including the creation of special drug treatment courts and the introduction of treatment orders for offenders with known dependence problems, the spread of urine testing programs in the work place and in prisons, as well as the remodelling of socio-community intake systems.

This association of drugs and crime sprang from fertile ground, for a number of reasons: changes caused by globalization and the realignment of the role of the state, which explain at least in part the increased social and economic inequalities between North and South, but also within countries, in the North and in the South; the increased insecurity of general living conditions following the 30 years, from 1945 to 1975, of unprecedented prosperity and employment security; divisions within communities caused by uncertainty and inability to manage mixed populations. For all these reasons the increase in "ordinary" crime (break and enter, car theft, vandalism and so on) has become the perfect metaphor for the insecurity of living conditions. Being

---

13 McCaffrey, B.R., Remarks before the First Annual Criminal Justice and Substance Abuse Conference, Albany, New York, June 29, 1999.

14 Testimony of Mr. Dale Orban, for the Canadian Police Association, before the Senate Special Committee on Illegal Drugs, in Senate of Canada, Issue No. 3, May 28, 2001, page 49.

15 Testimony of Mr. Michael J. Boyd, for the Canadian Association of Chiefs of Police, before the Senate Special Committee on Illegal Drugs, Senate of Canada, Issue No. 14, March 11, 2002, page 76.

an easy target that has considerable, very real impact on everyday life in neighbourhoods already subject to other social and economic problems, minor crime now elicited a stern, repressive response. Hence, in all Western countries, the number of prison terms and length of sentences increased starting in the mid-1980s. In addition to this collective security "crisis", there was a division between generations, as a result of which youths as a group came to be viewed as a source of concern, if not simply potential criminals. For example, during that period, Canada experienced an unprecedented increase in its reliance on detention for minors, placing it at the top of the list of industrialized countries in that regard.[16] Since young people are the principal drug users, the rest of equation was quickly established.

From anti-drug policies to drug policies

However, the advent of AIDS in the 1980s helped to cast doubt on prohibitionist policies on illegal drugs. Toward the end of the decade, it was discovered that intravenous drug users had a high rate of HIV and other pathologies such as hepatitis. In fact, intravenous drug use was the second leading cause of infection among men, after homosexual and bisexual practices, and the second leading cause as well among heterosexual women.[17] Repressive policies, based on prohibition of use, do not make it possible to adequately inform users or to adopt risk reduction and preventive measures, such as needle exchanges or supervised injection sites. The increase in harm reduction practices in a number of countries would be based on this new reality.

The creation of agencies monitoring illegal drug use trends was another factor in the questioning of drug policies. Until the mid-1980s, the U.S.A., England and Australia were virtually the only countries with systems for regular and repeated epidemiological surveying of drug use trends in the population. Starting in 1993, the European Union developed its tools to monitor trends in use and policy responses with the establishment of the European Monitoring Centre for Drugs and Drug Addiction and its focal points in individual EU countries. This regular monitoring system showed, among other things, that drug use trends may not vary so much with public policies as with social, cultural and symbolic factors.

Lastly, some states began to question their public policies on the basis of impact assessment studies. That was the case in particular of Australia and Switzerland as well as certain American states. Apart from the often emotional rhetoric, it was discovered in those studies that, in addition to having little impact on drug use, policies had significant untoward effects and high economic costs. It was moreover the results of certain cost benefit studies that led California and other U.S. states to review their

---

[16] On this point, see, *inter alia*, the work of Bala, N. (2002) *Juvenile Justice Systems. An International Comparison of Problems and Solutions.* Toronto: Thompson Educational Publishing.

[17] Riley, D., *op. cit.*, page 14.

highly repressive approaches (involving, for example, automatic incarceration on the third offence, whatever it might be).[18]

While national legislation on illegal drugs, particularly cannabis, did not in fact change, there was nevertheless a distinct trend toward questioning practices, particularly legal practices, and seeking alternatives while still complying with the international conventions. That was the case of Spain, Italy, certain Australian states, Belgium and, more recently, Portugal and Switzerland.

CHANGES IN CANADA

We have identified three major causes of change in Canada over the same period which have had at times paradoxical effects: the judicial activism resulting from the coming into force of the Canadian Charter of Rights and Freedoms in 1982, the adoption of the National Strategy on Community Safety and Crime Prevention and the fight against organized crime. Since we will be discussing each of these causes more fully in subsequent chapters of this report, we will only briefly sketch out the broader context here.

Judicial activism

With regard to cannabis, there is undoubtedly no better example than the decision by the Ontario Court of Appeal in the R. v. *Parker.*[19] In that case, the Ontario Appeal Court considered the constitutional validity of the prohibition against marijuana under the *Controlled Drugs and Substances Act* in the context of its use for medicinal purposes. The Court unanimously held that Terrance Parker's allegations that the prohibition violated his fundamental rights under section 7 of the Canadian Charter of Rights and Freedoms were founded. Rosenberg J.A., writing for the majority, found that Mr. Parker needed marijuana to control the symptoms of his epilepsy and that the prohibition against marijuana possession was accordingly unconstitutional. The Court thus held that the statutory provision was null and void. However, they suspended the declaration of invalidity for one year, thus giving the government time to amend the act accordingly. In July 2001, as a result of that decision, the government made regulations circumscribing the use of cannabis for medicinal purposes.

Other judicial decisions altered the applicability of drug legislation in various ways, particularly regarding police powers. Certain of these decisions are briefly reviewed in Chapters 14 and 15.

---

[18] See, for example, the study by Rydell, C.P. and S.S. Everingham (1994) *Controlling Cocaine: Supply vs. Demand Programs.* Rand: Santa Monica.

[19] R. v. Parker 49 O.R. (3d) 481.

Generally speaking, it has been observed that, since the Charter came into force, the courts have played an increasingly significant role in Canadian political life, and the drug issue has not fallen outside the scope of this judicial activism. Moreover, a decision on the issue of the use of cannabis for non-medicinal purposes is to be rendered by the Supreme Court of Canada in the coming months.

A national crime prevention strategy

In 1999, as a result of the work of the National Crime Prevention Council, the federal government introduced the National Strategy on Community Safety and Crime Prevention. The purpose of this national strategy, originally allocated an annual budget of $35 million, which increased to approximately $65 million this year, is to prevent crime through social development actions in the communities by taking action in particular on risk factors among children and youths. While the Strategy does not specifically mention prevention of drug use, a certain number of its projects and activities have focused on that issue in various ways.

The Centre has seen fit to fund two special drug treatment court pilot projects, in Toronto and Vancouver, for the purpose of preventing repeat drug abuse and related criminality. The Centre also supports an initiative of the Federation of Canadian Municipalities to introduce drug-free communities in a certain number of cities. It is also supporting the evaluation of alternative measures programs for youths accused of cannabis possession.

The fight against organized crime

If there is one legal subject that has given rise to extensive public debate, led to the passage of new legislation granting greater powers to police forces and resulted in spectacular police operations and no less spectacular trials, it is organized crime, in particular criminalized motorcycle gangs in Quebec, the Italian-Canadian Mafia in Montreal and the Asian heroin rings on the West Coast.

In 1995, Parliament passed Bill C-95 granting police officers more effective tools for investigating and prosecuting individuals taking part in gang activities. Four years later, three problems led the government to propose amendments to the *Criminal Code* and other statutes: the problems involved in implementing the act, the growing influence of organized crime in Canada and the illegal activities committed by police officers in undercover operations. In 1999, in passing Bill C-51 (an omnibus bill amending the *Criminal Code*), Parliament granted immunity from prosecution to police officers who had to commit offences related to money laundering in the course of an investigation or in performing other duties. According to the government, the purpose of that amendment was to support police officers in the fight against organized crime and money laundering.

In addition, on October 19, 2000, the Sub-Committee on Organized Crime of the House of Commons Standing Committee on Justice and Human Rights tabled a report proposing a series of amendments that could be made to the *Criminal Code* to facilitate the fight against criminal organizations. The Sub-Committee began its work in April 2000, and, in view of the nature of the subject under study, its members decided at the outset to perform their work in camera. Among other things, the Committee recommended that the *Criminal Code* be amended in such a way as to group together all provisions concerning activities relating to organized crime in a specific part entitled "Organized crime, designated substance offences, gangs and money laundering". A number of the Committee's recommendations were incorporated into Bill C-24, which received Royal Assent in December 2001.

A SOCIETAL DEBATE

These considerations of the global environment help put the drug issue in context. Always considered as a public security question, this issue more fundamentally concerns the upheavals societies are currently experiencing as a result of globalization. The place of drugs in those societies, which are shifting painfully from the modern to the post-modern world, attempting to reinvent society after individual destiny, so central to the cultural "revolutions" of the 1960s, has replaced family and collective destiny, raises questions about the boundaries of the individual and his relationship to others and about the very possibility of community given the significance of the individual. As the sociologist A. Ehrenberg has emphasized:

> [Translation] *(...) drugs appear as the condenser of uncertain responsibility. For democratic societies, it is the opportunity for a consideration of the limits of private freedom, that is to say of the tension between minimum contact with one's self, without which one cannot enter into relations with others, and minimum distance from self, without which one cannot make a society.* [20]

In another way, this is also what B. Alexander said in a brief he submitted to the Senate Committee:

> *Because western society is now based on free-market principles which mass-produce dislocation, and because dislocation is the precursor to addiction, addiction to drug use and to other substitute life styles within western society is not the pathological state of a few, but, to a greater or lesser degree, the general condition. Because free-market society increasingly provides the model for globalization, addiction is becoming more and more prevalent everywhere on earth (...).* [21]

[20] Ehrenberg, A. (1995) *L'individu incertain.* Paris: Calman Lévy, page 163.
[21] Alexander, B.K. (2000) "The globalization of addiction." *Addiction Research*, Vol. 8, No. 6, page 504.

As may be seen, the drug issue cannot simply be raised in terms of criminalization or decriminalization because it refers to much deeper societal issues relating to the role of government of the self in a context in which political government of the community is changing, and to the relationship between the two. Reducing the drug issue to a question of more or less repressive or more or less liberal criminal legislation is to rule out broader questions and to play the game of the particular interests of institutions which have every interest in reducing the figure of the addict to that of the "other", the deviant, the pathological case, and drugs to mere illegal drugs, whereas the faces of drugs are many and diverse. As the International Narcotics Control Board states in its 2000 report, trafficking in licit psychoactive drugs and their increased use are, in many respects, much more disturbing phenomena than the illegal drug market. There is a great risk that we will mistake the tip of the iceberg for the iceberg as a whole and allow ourselves to drift away on notions as simplifying as they are dangerous for a true public policy on drugs.

PART II

CANNABIS: EFFECTS, TYPES OF USE, ATTITUDES

CHAPTER 5

CANNABIS: FROM PLANT TO JOINT

Cannabis, marijuana, pot, grass, kif, grifa, ganja– from so many cultures, so many names for the drug made from *cannabis sativa indica*, one of the two main varieties of hemp. Beyond these various names are also different ways in which the drug is used and the context of those various usages: here marijuana is rolled with cigarette tobacco in a cigarette paper (joint), there kif is smoked in a pipe and elsewhere *ganja* is smoked in a water pipe. Sometimes it is baked into cookies or cakes. The French *pétard*, the English joint or the Indian *bangh* are all names for the product consumed and, at the same time designate different usages: marijuana is most often composed of the plant's flowering tops and dried, powdered leaves; *sinsemilla* is a preparation consisting of female tops of a private variety of seeds, whereas Indian ganja consists solely of fertilized flowering tops.[1]

These names are not mere accidents of folklore: like other substances, cannabis has codified uses that vary across cultures. The words used to name the same drug refer to a set of relations that populations of various cultures maintain with it, a kind of code of manners, but also of reasons to use the drug. In North America (United States and Canada), marijuana has long been identified with youth and the sexual liberation of the 1960s; in India and Jamaica, *ganja* has religious aspects which it does not necessarily possess in the West; and this same drug has still other cultural meanings in the Maghreb. We return to this question in Chapter 6.

This chapter first describes the cannabis plant and the various forms in which it becomes a consumer drug. We then take a brief look at the geographical origin of the cannabis plant and the routes along which it circulates in the modern world, noting at the same time its current modes of production (soil-based and hydroponic) which have developed in certain regions of Canada. We then describe the pharmacokinetics of the cannabis plant, in particular its main active ingredients and their metabolism in the body.

---

[1] See in particular INSERM (2001) *Cannabis. Quels effets sur le comportement et la santé ?* Paris: Les Éditions Inserm, page 143 passim; Ben Amar (in preparation); Wheelock, B.B. (2002) *Physiological and Psychological Effects of Cannabis: Review of the Findings.* Report prepared for the Senate Special Committee on Illegal Drugs, Ottawa: Senate of Canada.

ONE PLANT, VARIOUS DRUGS[2]

There are a number of varieties of cannabis. The best known are *Cannabis sativa, Cannabis indica* and *Cannabis ruderalis. Cannabis sativa* is the main variety which grows in virtually any climate. In dry, sandy and slightly alkaline soils, it yields plants that can reach up to seven meters in height. In Canada, the preferred variety for soil-based cultivation is *Cannabis indica*, which is a shorter plant, but with higher concentrations of Δ^{9-}THC (the main active ingredient of cannabis, discussed more fully below). There are male and female plants. In general, female plants are richer in Δ^{9-}THC than the males, which are often smaller and bare of leaves. Δ^{9-}THC is mainly found in the resin secreted by the flowering tops.

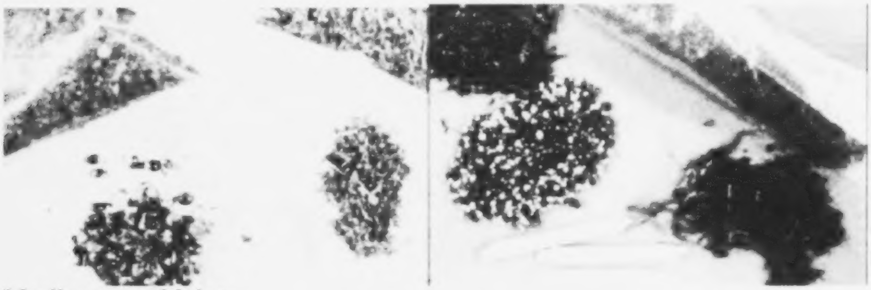
Flowering tops and leaves of cannabis

It appears that cannabis was first known in China some 6,000 years ago, then subsequently in India, then the Middle East, Africa, Mexico and South America. Cannabis can be cultivated in a number of ways, in greenhouses or hydroponically, which makes it possible to increase plant productivity and achieve high Δ^{9-}THC levels. Methods for genetically selecting the best greenhouse varieties and crops have also made it possible to increase the active ingredient content.

2 This section draws freely on various papers, in particular those by Ben Amar (in preparation), of INSERM, *op. cit.*, and Pelc, I., (2002) (ed.) *International Scientific Conference on Cannabis*, Brussels. In particular, we wish to thank Professor Ben Amar for his permission to reproduce the plates.

Male and female cannabis plants

Marijuana, which is a Mexican term initially used in reference to cheap tobacco, but which subsequently designated certain parts of the cannabis plant, is generally green or brown in colour and produces a characteristic odour when burned. It resembles oregano or coarse tea.[3] Marijuana comes from all the parts of the plant once dried. In this form, its THC content is lower; THC content is increased by selecting the flowering tops of the female plant. Dried and coarsely powdered, marijuana is most often rolled into thin cigarettes together with cigarette tobacco (joint), and sometimes smoked in a pipe or, less frequently, in cigar form. A typical joint contains between 0.5 and 1 g of cannabis. Like hash, it can also be baked into cookies and cakes, and be drunk as an herbal tea as well. A number of specialists told us that domestic cannabis made through controlled greenhouse production costs approximately $100 an ounce, and is then sold on the street at average prices ranging between $200 and $250. While we consider this estimated production cost high, the only other available studies concern production costs in developing countries such as Morocco.



Marijuana and joints

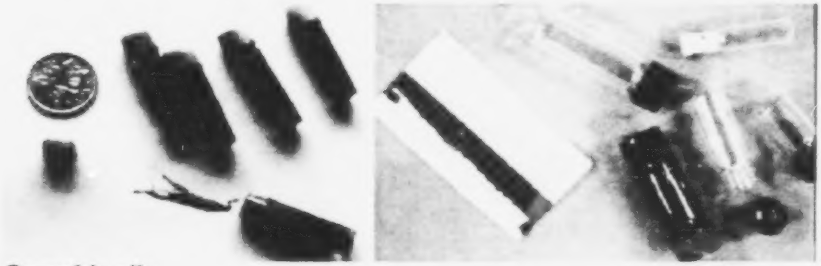
---

[3] On these questions, see in particular: McKim W.A. (2000) "Cannabis" in McKim, W.A. (ed.) *Drugs and Behaviour. An Introduction to Behavioral Pharmacology*. Upper Saddle River: Prentice Hall; Health Canada (1990) *Straight Facts About Drugs and Drug Abuse.* Ottawa: Department of Supply and Services; and Comité permanent de lutte à la toxicomanie (2001) *Drogues. Savoir plus. Risquer Moins.* (Édition québécoise) Montréal: Stanké.

Hashish, also known as hash, shit, kif (in North Africa) and *charas* (in India), is the viscous resin produced by the marijuana plant and obtained by pounding then compressing the dried leaves and flowering tops to obtain what, in France, is called a "barrette" or here a cube or block. It takes approximately 45 to 75 kg of cannabis to produce 1 kg of hash, which is sold in light brown to black pieces of hard or soft consistency. It is frequently smoked, alone or mixed with tobacco or marijuana, in a cigarette (joint), pipe or, more rarely, cigar. It may also be baked into cookies or cakes. The Δ^{9}-THC content of hash is generally between 3% and 6% in normal production. As is the case for cannabis, Δ^{9}-THC content can be increased through growing methods and resin concentrations to achieve levels of more than 10% on average. Slightly more expensive than marijuana, hashish sells for approximately $300 to $350 an ounce on the street.

Haschich

There are two other cannabis-based products, marijuana and hashish oils, which are extracted from resin using 90-proof alcohol, which is subsequently evaporated through exposure to the sun. These oils are viscous, greenish brown to blackish, foul-smelling liquids, with generally higher cannabinoid concentrations of up to 30% to 60% Δ^{9}-THC. Oils are generally dripped onto cigarette paper or tobacco then smoked. They are scarce and more expensive than other products.



Cannabis oils

The following passage from a report prepared by Labrousse and Romero for the *Observatoire français des drogues et des toxicomanies* (OFDT; French Monitoring Centre for Drugs and Drug Addictions) in 2001 on cannabis production in Morocco describes the various stages of production very clearly.

From Cannabis to Oil – The Production Process in Morocco

Kif is the name given to the cannabis plant as a whole. (…) Cut and dried in the sun (generally on rooftops) for at least a month and a half, it is preserved in houses for several months under plastic tarpaulins. Chopped by hand with a special knife on a board, it is then mixed with tobacco for smoking. The traditional mixture consists of one-third kif, two-thirds tobacco and is smoked in a *sebsi*, a long wooden pipe with a terracotta or stone pipe bowl.

Chira is the powder resulting from solidification of the small resin drops exuded by the flowering tops of the female plants. To separate the resin from the dried plants, processors pound or shake the plants over a stretched thin nylon veil that serves as a screen. The first powder to fall, golden beige in colour, is called *sigirma*. This is the top quality, so-called double-zero powder which is said to contain as much as 20% THC. The next powder to fall is called *hamda*, which is mixed with plant waste giving it a greenish colour. *Hamda* is lightly screened to yield various product qualities: zero, no. 1, no. 2, no. 3 and no. 4 (the lowest quality), containing respectively from 10% to 2% THC. (…) It takes approximately 100 kg of kif to obtain 1 kg of top-quality hashish.

Peasants (…) told us that the rest of the operation, when carried out by traffickers, took place in ostensibly secret buildings isolated in the mountains. (…) There the powder is placed in cellophane bags, then heated and compressed to yield resin or hashish, readied for the market in the form of small bars (generally 250 grams) called *tbisla* or "little plate". (…) The "double zero" quality, which derives its name from the two holes made in the bar with the end of a lit cigarette, is reserved for domestic consumption and preferred customers. Misinformed foreign customers often receive hash that has been cut with black polish, glue, henna, fig, earth or even medication.

(…) Cannabis oil is derived from no. 3 and no. 4 quality resins and produced by diluting hashish in a container with pharmaceutical alcohol. After six to eight hours of distillation, the liquid is filtered and stirred until all the alcohol has evaporated. Local production of this high value-added liquid (it takes 10 kg of hashish to produce one liter of oil) is less marginal than is generally thought.

Labrousse, A. and L. Romero (2001) *Rapport sur la situation du cannabis dans le RIF marocain*. Paris: OFDT.

CANNABIS ROADS

Where does the cannabis and hashish available in Canada come from? What quantities are imported and how much is produced locally? What routes are used to transport the drugs between provinces? What quantities are exported to other countries? What is the monetary value of this market? These are constantly recurring questions. They serve various purposes: to underline the scope of the drug "problem" generally, to explain the power of organized crime which makes money from drugs, as well as to substantiate the discrepancy between the size of the problem and the limited resources governments allocated to reducing supply. But this information can also assist in better understanding the extent of the problem experienced by peasants in the

various producer countries, the ecological issues raised by the cultivation of drugs, as well as the strategic position of drugs in geopolitics.

The cultivation of cannabis is the most widespread of all illegal drugs, which is not surprising since, not only does the plant grow readily in a number of climates, but it also requires little processing before becoming marijuana. According to the 2000 report of the *United Nations Drug Control Program* (UNDCP):

> *Over the last decade, 120 countries reported illicit cultivation of cannabis in their territory. Interpol identifies 67 source countries for cannabis through seizures made in 1998. (...) Estimating the extent of illicit cannabis cultivation, production and trafficking is much more difficult than for other plant-based drugs because of the significant amount of wild cannabis growth, the diverse nature of cultivation and the sheer magnitude of trafficking. In contrast to other plant-based narcotic drugs, illicit cannabis products can originate from three qualitatively distinct sources of supply: outdoor illicit cultivation; naturalized cannabis plant populations (wild growing cannabis); and plants cultivated indoors by means of sophisticated growing technology. (...) The large number of countries reporting an increase in cannabis consumption (two-thirds of all countries reporting drug abuse trends in 1996) would suggest that overall production must have increased; but this is only partly confirmed by seizure data. (...) Cultivation estimated (including wild growth), based on reports from Member States in the 1990s, ranges from 670,000 hectares to 1,850,000 hectares. Production estimates vary by a factor of 30, from 10,000 tonnes to 300,000 tonnes. Linking production and consumption estimates, UNDCP estimates world wide cannabis production to be at about 30,000 tonnes.*[4]

As may be seen, estimates vary greatly and are enormously difficult to validate. How can anyone estimate the number of cannabis plants that are transformed into marijuana? The data provided by the governments of various countries on cultivated areas are themselves only approximations. As to the number of greenhouses and other forms of production, there is quite literally no way of knowing.

The work of the team at France's *Observatoire géopolitique des drogues*, under the direction of Alain Labrousse, is exemplary in the field. The box from the same report produced for the OFDT in 2001, describes a three-month field project in which the authors cross-checked data from various sources.

Variable Estimates – The Case of Morocco

In their study, Labrousse and Romero state that, according to the Department of Agriculture, cannabis was produced on 75,000 hectares in 2000. (By comparison, in its 2000 report, the ODCCP cites the figure of 50,000 hectares in cannabis production in Morocco, an official figure provided by the Department of the Interior.)

Based on their own work in the field, they estimate that 90,000 hectares were in production in 1999 and between 110,000 and 120,000 in 2001. That production involved approximately 200,000 families, between one and one and a half million persons. Based on those areas, production would be between 1,600 and 3,000 tonnes, after deducting the quantities of kif set aside for national consumption.

Labrousse and Romero, *op. cit.*

[4] United Nations Office for Drug Control and Crime Prevention (2001) *World Drug Report 2001*. Oxford: Oxford University Press, pages 30-32. Available on line at http://www.undcp.org/adhoc/world_drug_report_2000/report_2001-01-22_1.pdf.

In particular, it has been observed that, when linked to the population of potential cannabis users (which the Centre estimates at some 120 million persons), the estimated global production of 30,000 tonnes is much nearer the 10,000 tonne floor than the 300,000 tonne ceiling.

According to the UNDCP, the main producers are Colombia and Mexico (marijuana) and Morocco (hashish). According to the International Criminal Police Organization (Interpol), Morocco, Afghanistan and Pakistan are the main sources of hashish and Colombia, Niger and South Africa of cannabis. Lastly, according to Labrousse, marijuana production is exploding, with Colombia becoming again the major producer it was in the 1970s, and production rapidly increasing in West Africa (Nigeria, Ghana, Congo, Ivory Coat, Senegal), although the great steppes of the Commonwealth of Independent States (Kazakhstan, Kirghizistan, Ukraine, Belarus and Azerbaijan) have virtually unlimited export potential, while Afghanistan and Pakistan likely produce 2,000 tonnes of hashish, the equivalent of Morocco's production.[5] In addition, Canada has been a cannabis exporting country for a number of years now.[6]

Traditionally, the cannabis available in Canada comes mainly from Mexico, Jamaica and the countries of the horn of Africa, while hashish originates mainly in Asia and the Middle East:

> *The hashish market in Central Eastern Canada is known world-wide. U.S. criminals are among the international traffickers who orchestrate multi-tonne shipments of this drug from Pakistan directly to Montreal by mothership or container. In 2001, some shipments transited the United Arab Emirates, Africa and Europe before reaching Canada. Multi-kilo quantities are also imported from Jamaica by couriers travelling on board commercial airlines.*[7]

While a large portion of cannabis sold in the Canadian market was of foreign origin until the 1980s, the situation has radically changed since that time. It is estimated that national production has now supplanted imports. In its 1999 report, the Royal Canadian Mounted Police writes:

> *It is estimated that more than 50% of the marihuana available in Canada is produced domestically. Of the foreign marihuana seized in or en route to Canada in 1999, at least 5,535 kilograms originated from Jamaica, 825 kilograms from South Africa and 860 kilograms from Mexico. Foreign shipments arrive directly into Canadian ports of entry or transit through the United States before reaching Canada. On June 11, 1999, U.S. Customs intercepted 2,464 kg of Jamaican marihuana and 141 kg of hash oil at Newark, New Jersey in a marine container bound for Montreal. Furthermore in Project JOULE*

---

[5] Labrousse, A. (2000) *Drogues. Un marché de dupes.* Paris: éditions alternatives; see also "L'approvisionnement des marchés des drogues dans l'espace Schengen." *Les Cahiers de la Sécurité Intérieure*, 32, 2e trimestre 1998.

[6] See, for example, in OGD (1996) *Atlas mondial des drogues.* Paris: PUF.

[7] Royal Canadian Mounted Police (2002) *Drug Situation in Canada (2001)*. Ottawa: author.

on June 20, 1999, 2,617 kg of Jamaican marihuana destined for Canada were seized in Stuart, Florida. [8]

How much cannabis and hashish are available in Canada? What is the monetary value of those drugs? It is in fact impossible to answer these questions, for obvious reasons, since the drugs are illegal. While we know the amount of tobacco produced and sold in cigarette form, and the volume of alcohol produced or imported and consumed, and sales turnover can be calculated in both cases on the basis of those volumes, it is impossible to do this for illegal drugs.

For a time, the United Nations International Drug Control Program suggested that the total value of the illegal drug "industry" was approximately US $400 billion, greater than the oil industry.[9] The total value of cannabis obviously cannot be separated from that amount, even though we know that the largest number of persons who use drugs use cannabis. No one really knows how or on what basis these figures are advanced, whether they were produced using a rigorous calculation method or merely noted down on a napkin over a meal.[10] And yet they often serve as a reference. In a series of articles published on the illicit drug issue in 2001, *The Economist* cited the $400 billion amount before suggesting a more conservative estimate of US $150 billion.[11] By comparison, the value of the pharmaceutical industry is near US $300 billion, that of the tobacco industry $204 billion and that of the alcoholic beverages industry $250 billion.

Since the authors provide itemized accounts of their calculation methods, we will now continue our analysis of the Moroccan example.

[8] Royal Canadian Mounted Police (2000) *Drug Situation in Canada (1999)*. Ottawa: author.

[9] UNDCP (2000) *op. cit.*

[10] The Committee invited the Executive Director of UNDCP or a delegate to testify before it, but the invitation was turned down.

[11] "Stumbling in the Dark", *The Economist*, July 28 - August 3, 2001.

Yields and Returns from Cannabis – The Case of Morocco

Cannabis is a not very demanding plant that grows in poor soils, which it quite quickly renders unfit for any other form of agriculture. As a result of the illegal nature of this crop, the income it generates is disproportionately high compared to that from legal food and cash crops. It is also a non-perishable product that can be sold from the home, into an ever certain market and on credit. In particular, it enables local populations to improve their living conditions and opens the way to initiatives by the peasants themselves.

Estimates of per-hectare cannabis income vary with soil type, rainfall, degree of irrigation, whether the cannabis is processed into chira (powder), period of sale and other factors. In addition, researchers give various estimates based on the same criteria. This is due to the fact that it is difficult to obtain reliable data from mistrustful peasant farmers. Income from the production of unprocessed kif varies, depending on sources, from 12,450 to 210,000 French francs per hectare.

(…) while cannabis is highly profitable on irrigated perimeters, it is much less so on pluvial lands, particularly in poor years. (…) Many peasant farmers who likely cultivate only 1.5 ha to 3 ha (non irrigated) of cannabis, earn, in poor years, only 20,000 F to 40,000 F from that crop to support families of, in many cases, more than 10 persons.

(But) cannabis is 12 to 46 times more profitable than grain crops.

In 1997, based on production of 1,397 tonnes of hashish for the Rif as a whole, Pascual Moreno estimated the return for Moroccan producers (from the peasant farmer to the major trafficker) at $1.816 billion. Since a certain number of Moroccan traffickers operate outside the country, Moreno estimated the return to the Moroccan economy from cannabis profits at $2 billion, compared to $750 million for textile exports, $460 million from foreign investments and $1.26 billion for tourism. He also estimated the profits of European traffickers at $3 billion (apparently not including street sales).

However, since cannabis is more profitable than any other crop, peasant farmers tend to abandon food crops and to supply themselves from the market. As a result, there is a growing food shortage in the region.

Labrousse and Romero (2001) *op. cit.*: 12-15

We know of no similar field work for Canada or Mexico. In addition, in Canada, climatic conditions have stimulated development of greenhouse and hydroponic crops, and the ratio of these cultivation methods to soil cultivation methods is not known.

We therefore use the following figures and data on cannabis production, cannabis and hashish imports and the monetary value of those drugs in the Canadian market, with considerable reservation and prudence.

According to the RCMP, "*the annual production of marijuana in Canada [is] at least in the 800 tonne range. This estimate appears overwhelming, however investigators believe it is quite conservative, and it is supported by intelligence and seizures of marijuana in plant and bulk forms.*"[12] The same figures are stated in the 1998 and 2002 reports. Note as well that, at 800 tonnes, Canadian production represents approximately 2.5% of global production, as stated by the UNDCP.

In its 1998-1999 annual report, the Observatoire géopolitique des drogues stated that, based on police sources, the value of the illegal drug market in Canada was $7 billion to $10 billion a year.[13] For 2001, the RCMP estimated that the market value

[12] Royal Canadian Mounted Police (2000), *op.cit.*

[13] World Geopolitics of Drugs (1999) *Annual Report 1998/1999*. Paris: WGD, page 178.

of all illegal drugs was $18 billion.[14] It is impossible to estimate the share of cannabis and hashish in that total. As we most often do not know the calculation basis for these estimates, they must also be prudently considered. As the Assistant Deputy Solicitor General stated in his appearance before the Committee, the calculation methods, based on the assumption that police and customs organizations seize 10% of all drugs, are unscientific and unreliable.[15] We nevertheless note an apparent inconsistency: the seeming stagnation of cannabis production at 800 tonnes and of hashish imports at 100 tonnes since 1998, as well as the declining prices of heroin and cocaine in a stable, even declining market (RCMP reports) are not consistent with the presumed doubling in total value of the drug market. As a result, in dealing with these various estimates of the quantity of drugs produced and monetary value of the drug market, the Committee often had the impression that, ultimately, no one really knew how big it was.

With regard to hashish, the RCMP believes that it

> *is easier to estimate the quantity of hashish entering the Canadian market annually than the quantity of any other illegal drug. Unlike what is observed for other drugs, such as cocaine and marijuana, that can be found across Canada and the United States, hashish use in North America is a localized phenomenon. The drug is very popular in Quebec, Ontario and the Atlantic Provinces, whereas demand is limited elsewhere in Canada and supply is sporadic at best in the northeastern United States. Consequently, Montreal organized criminal groups are specialized in the massive importing of hashish and have a monopoly on its distribution in bulk. In view of these facts and of information on multi-tonne hashish shipments seized in Canada and abroad and on those we know have entered the Canadian market, RCMP analysts estimate that at least 100 tonnes of the drug are imported into Canada each year.*[16]

Canada is also an in-transit country for drugs to the United States, and a significant portion of Canadian cannabis is intended for export, in particular to that country.

> *Smuggling of Canadian marihuana to the United States remains a source of concern for enforcement officials on both sides of the border. Though this activity is particularly noticeable on the British Columbia–U.S. border, it is not limited to that province. There is intelligence that the Hell's Angels in Quebec are supplying marihuana to their U.S. counterparts. Intelligence also indicates that there is marihuana smuggling activity across the Great Lakes. Despite the foregoing, few U.S. marihuana seizures can be traced back to Canada.*[17]

In 1999, Washington officials suggested that Canada could be placed on the list of countries suspected of a soft stance in the fight against drug production and trafficking.

---

14 Greater Toronto Area Combined Forces Special Unit (2002) *Fact Sheet - Heroin*. Available on line at: http://www.cfseu.org/heroin.html.

15 Mr. Paul Kennedy, Testimony before the Senate Special Committee on Illegal Drugs, June 10, 2002.

16 *Ibid.*

17 Royal Canadian Mounted Police (2000) *op. cit.*.

More recently, officials of the Drug Enforcement Administration repeated that Canada's trafficking in cannabis toward the United States was a significant problem. One RCMP officer told a national newspaper that approximately 70% of marijuana grown in Canada wound up in the United States,[18] whereas, according to the 2002 report of the International Drug Control Agency, the figure was approximately 60%.[19] We have heard, and RCMP officers confirmed it, that cannabis from British Columbia has such a high value that it was traded on par with cocaine. According to those police officers specialized in the war on drugs, British Columbia's triple A quality cannabis is worth approximately $4,000 a pound in Canada and one kilogram of cocaine is currently worth US $11,000. However, while reference is made to this supposition in the annual report for 1999, it is not confirmed:

> *Canadian marihuana is sometimes used as a currency to purchase cocaine that is warehoused in the U.S.A. The exchange ratio is about three to one. Exchanges of one to one have been rumoured but never substantiated. Furthermore, such a rate of exchange does not make sound commercial sense considering that a kilo of cocaine sells for $13,000 U.S. (in lots of 50 kilos or more) while the wholesale price of a kilo of marihuana ranges around $6,000 or $8,000 U.S.* [20]

In its 2002 report, the RCMP merely mentions the fact that Canadian cannabis is exchanged for cocaine, without saying whether it is on an equal weights basis. We also note a certain inconsistency here as the price of a kilogram of cocaine is expressed in US dollars, whereas that of a kilogram of marijuana is expressed sometimes in Canadian dollars, at other times in US dollars.

British Columbia, Ontario and Quebec are the main producers in Canada. British Columbia's large production can be attributed in particular to suitable climatic conditions, but there are probably also sociocultural explanations, as the Pacific Coast mentality explains in part why cannabis appears to have taken root there to a greater extent.

Cannabis production in British Columbia appears to have increased significantly over the past 10 years, becoming, according to some analysts, one of the province's biggest industries in terms of monetary value, which some analysts set at $6 billion, whereas, according to some police officers, a conservative estimate would be $4 billion.[21] If marijuana sells for $225 an ounce, at 16 ounces a pound, British Columbia would appear to produce the equivalent of 550 tonnes of cannabis a year, more than two-thirds of the total amount of cannabis circulating in Canada.

---

[18] National Post, May 17, 2002. The Committee is interested, and somewhat amused, to note that this article and a previous report on the Global television network on May 13, 2002, outlining the concerns of American representatives, followed the Committee's publication of its Discussion Paper.

[19] International Narcotics Control Board (2001) *Report of the International Narcotics Control Board for 2000.* Available on line at: http://www.incb.org.

[20] Royal Canadian Mounted Police (2000) *op. cit.*.

[21] RCMP, private meeting.

Testifying in Richmond, B.C., on 14 May 2002, RCMP Superintendent Clapham said there were between 15,000 and 20,000 illegal cannabis production sites in British Columbia (figures from the Drug Enforcement Administration), while RCMP narcotics specialists, the next day, put the figure at 7,000. Regardless of the true number, the figures, as may be seen, must necessarily be considered very carefully.

As to growing methods, soil-based production is still the most popular, but the more sophisticated, hydroponic and aeroponic,[22] methods are expanding, particularly among criminal gangs that have the necessary infrastructure.

> *It is not uncommon to find indoor grow operations involving over 3,000 plants. Those figures vary considerably from one province to another, overall less than 10 percent of all marihuana seized in Canada was grown using hydroponics (a method of growing plants with the roots in nutrient mineral solutions rather than in soil). Indoor grow operations still rely mostly on soil-based organic cultivation but hydroponics is gaining in popularity. Despite the availability of highly sophisticated technologies designed to increase the yield even more, most growers do not bother to go to such lengths, preferring simpler and proven methods. Marihuana remains the most popular illicit drug, both in terms of consumption and trafficking. The annual marihuana production has been estimated to be around five million plants. Given the relatively low cost of setting up a grow operation and the considerable profits it generates, this activity has become increasingly attractive, even to otherwise law-abiding citizens. In the majority of regions, large operations are invariably run by outlaw motorcycle gangs, although Asian-based organizations have been making inroads in British Columbia and Alberta. More and more groups are using "crop sitters" and other go-betweens to tend their plantations. This hands-off approach makes it difficult for police to link the operation to the people who are actually behind it. Outdoor crops are often grown on Crown lands located in remote areas in order to reduce the risk of detection.*[23]

In all, with considerable reservations as to the validity of the data, the Committee submits the following:

	Marijuana	Hashish
Estimated quantity	800 tonnes	100 tonnes
- national production	approximately 50%	?
Source	National production (British Columbia, Ontario, Quebec) Imports: Mexico, Jamaica	Imports: Pakistan, Afghanistan, Morocco
Value (wholesale)	$2,000 to $4,000/pound	?
Retail value (ounce)	$225 to $250	$325 to $350

[22] Technique whereby the roots are suspended and sprayed regularly with water enriched with nutrient material, still very rare and the effectiveness of which remains to be proven. (Source: RCMP (2002)).
[23] RCMP, Drug Situation in Canada (1999) *op. cit.*.

PROPERTIES OF CANNABIS

Classified in the pharmacopoeia as a hallucinogenic, psychodysleptic or psychotomimetic, cannabis is a disrupter or modulator, that is to say that it alters perceptions and emotions. Classified in the international conventions and national legislation as a narcotic, cannabis belongs to the class of psychotropics which comprises five major groups: depressants (alcohol, Valium), stimulants, minor (coffee, nicotine) and major (cocaine, amphetamines), disrupters (cannabis, LSD), antipsychotics and medication for mood disorders (lithium).

More than 460 known chemical constituents are present in cannabis.[24] Of that number, more than 60 are identified as cannabinoids. The main active ingredient in cannabis, which was identified by the team of Dr. Mechoulam in 1964,[25] is Δ^9-tetrahydrocannabinol, common called THC. Other cannabinoids present in Indian hemp include delta-8-tetrahydrocannabinol, cannabinol and cannabidiol, but they are present in small quantities and have no significant effect on behaviour, compared to Δ^{9}-THC,[26] although they can modulate the product's overall effect.[27] Cannabinol also has anti-inflammatory effects.

For a better understanding of the effects of cannabis discussed in the following chapters, we will first consider its pharmacological properties. Consequently, readers may skip this technical section without risk of not properly understanding the rest of the report. In the following paragraphs, we first discuss Δ^9THC levels and, second, specifically examine the pharmacological properties of that substance.

---

[24] See in particular Grinspoon, L. and J.B. Bakalar (1997) *Marijuana. The Forbidden Medicine.* New Haven and London: Yale University Press; Clark P.A. (2000) "The ethics of medical marijuana: government restrictions vs. medical necessity", *Journal of Public Health Policy*, 21: 40-60; as well as Wheelock (2002) for the Senate Committee.

[25] Gaoni, Y. and R. Mechoulam (1964) "Isolation, structure and partial synthesis of an active constituent of hashish", *Journal of the American Chemistry Society*, 86: 1646-1647; and Mechoulam, R. and Y. Gaoni (1965) "A total synthesis of delta-9-tetrahydrocannabinol, the active constituent of hashish", *Journal of the American Chemistry Society*, 87: 3273-3275.

[26] Smith, D.E. (1998) "Review of the American Medical Association Council on Scientific Affairs Report on Medical Marijuana", *Journal of Psychoactive Drugs.* 30: 127-136; McKim W.A. (2000) "Cannabis", in McKim, W.A. (ed.) *Drugs and Behavior. An introduction to behavioral pharmacology.* Upper Saddle River: Prentice Hall.

[27] Ashton, C.H. (2001) "Pharmacology and effects of cannabis: a brief review", *British Journal of Psychiatry.* 178: 101-106.

Δ^9THC Concentrations

The Δ^9THC content of marijuana generally varies in natural growing conditions from 0.5 to 4%.[28] Δ^9THC content serves first as a basis for distinguishing the drug type of plant from the fibre type: permitted concentrations vary by country - in Canada, as in France, it is 0.3% for the fibre type. For more than a decade now, techniques for selecting powerful strains and cultivation (in greenhouses and hydroponically) have made it possible to achieve Δ^9THC concentrations of 15% or more. Δ^9THC content is also used to distinguish between various cannabis products and thus to determine their price: the content of sinsemilla, for example, generally varies between 7% and 14% and is more expensive than "regular" cannabis.

The question of Δ^9THC content, its variability, how it is determined and its effects has raised numerous issues. While all specialists agree that maximum active ingredient concentrations have increased over the past 20 years, opinion is divided on average concentrations in cannabis available on the market. Estimates vary as to the preponderance and consequences of Δ^9THC concentrations.

First, it should be emphasized that studies show that concentrations are subject to extreme variability, for a number of reasons. First, failing a control system at source, the Δ^9THC content of marijuana is estimated on the basis of police seizures. However, only a portion of the drug seized is analyzed for THC content,[29] and analyses are not all equally reliable, depending on how police or customs officials conducted the seizures and how the products were preserved and transported to the lab. In addition, between a seized product in clandestine lab or at a customs post and the product sold on the street, a number of changes can be made: tobacco, herbs and other products can be added to the gram of "pot" sold at a school which alter the nature of the drug and thus the quantity of active ingredient. This is even truer for hashish, as seen above in the example on processing in Morocco.

Second, since cannabis is a widespread illegal product, it is impossible to take a representative sample of the drug available on the market at a given time for analysis. Thus it is impossible to measure the difference between the Δ^9THC content of cannabis seized at the production or delivery site and that of cannabis used by individuals. And third, the active ingredient concentration varies with the geographical area of origin, climatic conditions and production conditions. Likely circulating in the

---

[28] Huestis, M.A *et al.* (1992) "Characterization of the absorption phase of marijuana smoking", *Clinical Pharmacology and Therapeutics*, 52: 31-41.

[29] Note, for example, that, in the United States, there is no systematic method for measuring THC. As emphasized in a comparative analysis of changes in price of heroin, cocaine and marijuana, "Another problem is that the DEA does not test marijuana for THC content, so there is no marijuana counterpart to the pure grams reported for cocaine and heroin. The difficulty this causes is the STRIDE data provide no basis for adjusting price changes for marijuana's quality." Abt Associates (2001) *The Price of Illicit Drugs: 1981 through the Second Quarter of 2000.* Washington, DC. Report prepared for the Office on National Drug Control Policy.

market at any given time is a significant variety of cannabis products reflecting the diverse conditions in which they were produced. It follows that two samples seized in Vancouver in the same week could have very different concentrations, as would be the case for samples seized the same week in Vancouver, Montreal and St. John's.

Experts told the Committee that cannabis in the Canadian market was 700% more powerful than the same drug in the 1970s. Some suggested that the average Δ^9THC content of cannabis on the market is approximately 30%, compared to 3% to 4% in the 1970s.

> *The cannabis used today is up to 500 percent higher in THC - that is a range between five percent to 31 percent - than the cannabis most adults remember from the 1960s and 1970s.*[30]

In its 1999 annual report, the Royal Canadian Mounted Police estimated the average content of seizures at 6%.[31] In Quebec, the Montreal Police Department asserted that the THC content of cannabis is now 25%. In a private meeting with Committee members, RCMP narcotics experts in British Columbia emphasized that it is *impossible in the current state of affairs to determine the average content of cannabis in the country* or in a given province, in particular as a result of the extreme variability of seizures and methods of analysis. The officers who conduct the seizures do not always pay attention to the manner in which they preserve the product, such that it may lose its Δ^9THC content: heat, light and humidity affect the stability of cannabis. Lastly, the experts providing cannabis for therapeutic purposes whom we met said they kept various grades of cannabis, based in particular on Δ^9THC concentrations, and that, in certain cases, the products offered to patients reached concentrations of 27%.

The most exhaustive studies on changes in Δ^9THC levels in cannabis have been conducted in Australia, the Netherlands, France and the United States. They show, first, that more powerful products have appeared in the market beside the traditional forms of cannabis: "skunk" (a variety originating in the United States and the Netherlands), "super-skunk" and "pollen" (stamens of male plants). Canada has not lagged behind, with *BC Bud* and *Quebec Gold* in particular.

More specifically, the studies on Δ^9THC concentrations show similar trends:

- In Australia, a study by Wayne and Wendy on 31,000 seizures conducted between 1980 and 1997 shows that average content varied little over the period and was between 0,6 % and 13 %. Among other things, it appears that the main development has been a more significant selection than

---

[30] Testimony of Mchael J. Boyd, Chair of the Drug Abuse Committee and Deputy Chief of the Toronto Police Service, for the Canadian Association of Chiefs of Police, Senate Special Committee on Illegal Drugs, Issue No. 14, page 74.

[31] Royal Canadian Mounted Police (1999), *Annual Report.*

previously of the parts of the plant with the highest concentrations.[32] The authors of this study make the following observation which applies equally to Canada:

> *A number of factors probably explain the persistence of the belief that the THC content of cannabis plants in Australia has increased 30 fold in the absence of any supporting data. First, defenders of the claim often point to reports of single samples with unusually high THC content tested by the police. At best, such samples indicate the maximum THC content that has been achieved (assuming that there were no errors in the test results) but they do not tell us what the THC content is in the cannabis that is typically used by consumers. Second, biases in the sampling of tested cannabis are amplified by the attention that the print and electronic media give to unusually potent samples, creating the false impression that cannabis with exceptionally high THC is the norm. Third, uncontested repetition of these assertions in the media has established them as "fats"; those who context these claims are asked to prove that they are false rather than the (usually nameless) proponents being asked to provide evidence that they are true. Fourth, an increase in average THC content seems to explain an apparent increase in the number of cannabis users who experience problems as a consequence of their use.* [33]

- In the Netherlands, the *Drug Information Monitoring System* of the Trimbos Institute has conducted various studies since 2000 on average Δ^9THC content. The local variety, *Nether-Weed,* contained an average of 8.6% THC in 2000 and 11.3% in 2001, whereas imported varieties were stable at approximately 5%. One of the reasons given for this difference was that the local variety was fresher and contained a lower ratio of cannabinol to Δ^9THC. In addition, *Nether-Weed* resembles sinsemilla, which comes from the unfertilized flowers of the female plant and is cultivated in greenhouses.
- In France, the Roques report referred to concentrations of up to 20% in the case of certain Dutch hydroponic varieties.[34] In its recent report, France's *Institut national de la santé et de la recherche médicale* notes a toxicological study conducted by Mura on the Δ^9THC concentrations of seizures since 1993. From 1993 to 1995, the average concentration was 5.5%, but approximately 8% since 1996, with spikes of up to 22%.[35] In 2000, 3% of marijuana samples analyzed contained Δ^9THC levels of more than 15%.
- Lastly, in the United States, data for 2000 show an average concentration of 6%, compared to 4.1% in 1997. In fact, recalling a study recently conducted in Mississippi, Dr. John Morgan noted:

---

32 Wayne, H. and S. Wendy (2000) "The THC content of cannabis in Australia: evidence and implications", *Australian and New Zealand Journal of Public Health.* 24: 503-508.

33 *Ibid.*, page 504.

34 Roques, B. (1999) *La dangerosité des drogues.* Paris: Odile Jacob.

35 INSERM (2001) *Cannabis: quels effets sur le comportement et la santé?* Paris: Les Éditions Inserm.

(...) in the midst of this furore over the remarkable increases in marijuana potency, it is interesting that the potency of the commercial crop sold in the United States has not varied enormously over the 30 years that potency has been assessed by the analysis of THC content in criminally seized marijuana. In fact, I recently looked at the report, which also comes from Mississippi, that the mean THC content of some 40,000 seizures since 1974 is about three percent. It has gone up in the last 10 years. In fact, in the last 10 years I believe the arithmetic mean is more than four percent while in the 10 years before that it was about 3.5 percent. [36]

The following table summarizes some of the data on a historical basis for certain countries.

Year analysed	Domestic Marijuana (USA) Foreign Marijuana (Netherlands)			Sinsemilla (USA) Nether-Weed (Netherlands)		
	= 3 %	= 5 %	= 9 %	= 3 %	= 5 %	= 9 %
USA, 1996[1]	63%	25%	3%	93%	77%	49%
USA, 1997[1]	63%	29%	6%	96%	85%	64%
USA, 2000[2]	Average of 6.07% (DEA)			Average of 13,65% (DEA)		
Netherlands, 2000-2001[1]	75%	48%	7%	93%	87%	35%
Netherlands, 2001-2002[1]	80%	55%	4%	100%	99%	78%
Australia, 1997[3]	Between 0.6% and 13%					
Western Australia	Average of 3,8%					
Canada 1999[4]	Average of 6%			Not available		

(1) Source: Rigter H. and M. von Laar (2002) " Epidemiological Aspects of Cannabis Use", International Scientific Conference on Cannabis, Brussels, page 32.

(2) Drug Enforcement Administration, http://www.usdoj.gov/dea/concern/marijuana.html

(3) Source: Hall, W. and W. Swift (2000) *op. cit.*, page 505

(4) Source: RCMP, Annual Report for 1999.

In short, it appears that the main change has been in maximum concentrations obtained as a result of sophisticated cross-breeding and cultivation methods, whereas average concentrations have not significantly changed over the past 30 years.[37] What conclusion can be drawn from this? In the minds of some, if cannabis could still be called a "soft drug" in the 1970s, that is no longer the case today. Some are not reluctant to say it is a drug comparable to heroin or cocaine in its addictive power. As an example, the Canadian Police Association has issued the following opinion on the risks associated with cannabis.

Generally, marijuana and its derivative products are described [as soft drugs] to distance the drug from the recognized harm associated with other illegal drugs. This has been a successful yet dangerous approach

[36] Dr. John Morgan, Professor at the City University of New York Medical School, testimony before the Senate Special Committee on Illegal Drugs, June 11, 2001, Issue No. 4, page 29.

[37] ElSohly, M.A., *et al.* (2000) "Potency trends of delta9-THC and other cannabinoids in confiscated marijuana from 1980-1997", *Journal of Forensic Sciences*, 45(1): 24-30.

> *and contributes to the misinformation, misunderstanding and increasing tolerance associated with marijuana use. Marijuana is a powerful drug with a variety of effects. (...) Marijuana use is associated with poor work and school performance and learning problems for younger users. Marijuana is internationally recognized as a gateway drug for other drug use. Risk factors for marijuana dependence are similar to those of other forms of drug abuse.* [38]

Others associated the increase in demand for treatment for cannabis dependence with the increase in active ingredient concentrations. As the National Post reported:

> *The potent BC Bud, which has a THC content as high as 25% compared to the 2% typical in the 1970s, is also leading to health concerns in the United States. Admissions for marijuana drug treatment in Washington State now exceed the rate for treatment of alcoholism. Cannabis admissions in Cook County, Ill., have risen by 400% in the last year.* [39]

Can it be said that cannabis has in fact become a "hard" drug like cocaine and heroin? Apart from the validity of the effects of cannabis itself as described by the Police Association, and as will be discussed in detail in the Chapter 7, that contention does not take into account the way in which the drug is used or the lack of knowledge of the effects of Δ^9THC concentrations. Studies on the ways in which cannabis is used, considered in Chapter 6, show that regular users appear to prefer medium to mild cannabis, and that they adjust their use to the strength of the drug. Interviews with individuals who use cannabis for medical purposes tend moreover to confirm this perception. More significantly, for lack of any specific studies on the question, the effects of higher Δ^9THC concentrations are simply not known. Lastly, as will be shown in the following section, the bio-availability of Δ^9THC, that is to say the proportion that is actually absorbed by the body following combustion, is highly variable. As emphasized in the report of the World Health Organization (WHO) on cannabis, considering all these factors, the actual quantity of THC absorbed by the cannabis user is difficult to estimate.[40] Ultimately, while it can be a legitimate preoccupation, the real issue of Δ^9THC content has more to do with our ability to control it and better know its effects, rather than making all kinds of alarmist and unfounded statements about its level.

---

38 Sergeant Dale Orban, Regina Police, at the Senate Committee hearing on May 28, 2001.

39 National Post, May 17, 2002.

40 World Health Organization (1997) *Cannabis: a health perspective and research agenda.* Geneva: WHO, 1997. On line at: www.who.org.

Pharmacokinetics[41]

Upon inhalation, and depending on the smoker's way of smoking and smoking experience, between 15% and 50% of the Δ⁹THC present in the smoke is absorbed into the bloodstream. The percentage also depends on the Δ⁹THC concentration in the smoked product. The substance is absorbed very quickly, and maximum blood concentrations are achieved in less than 15 minutes after the start of inhalation. The effects felt almost immediately after absorbing the smoke diminish gradually over the next 60 minutes and generally last a maximum of three hours after inhalation. In other words, THC levels in the blood plasma are highest immediately after absorption, whereas maximum effects are felt approximately 30 to 40 minutes later. The following table reproduced from the ISERM collective assessment, shows the time to appearance and duration of detection of cannabinoids in the blood.[42]

Concentration, time to appearance[1] and duration of detection[2] of cannabinoids in the blood after smoking a marijuana cigarette containing 15.8 mg or 33.8 mg of Δ⁹THC

Component	Maximum concentration	Time to appearance of peak (hr)	Duration of detection (hr)
Δ⁹THC	84.3 (50-129)[3]	0.14 (0.10-0.17)	7.3 (3-12)
	162.2 (76-267)[4]	0.14 (0.08-0.17)	12.5 (6-27)
11-OH-Δ⁹THC	6.7 (3.3-10.4)	0.25 (0.15-0.38)	4.5 (0.54-12)
	7.5 (3.8-16.0)	0.20 (0.15-0.25)	11.2 (2.2-27)
Δ⁹THC-COOH	24.5 (15-54)	2.43 (0.8-4.0)	84.0 (48-168)
	54.0 (22-101)	1.35 (0.54-2.21)	152.0 (72-168)

(1) average interval between start of consumption and appearance of a concentration peak
(2) average interval between start of consumption and moment when lowest concentration of component is detected (> 0.5 mg/ml)
(3) cigarette containing 13.8 mg (1.75%) of Δ⁹THC
(4) cigarette containing 33.8 mg (3.55%) of Δ⁹THC

Bio-availability of Δ⁹THC is slower and weaker when the drug is ingested orally (cookies, cakes, herbal teas): approximately 4% to 12%; although slower to be felt and different in quality, its effects are longer lasting.

In all, we do not know how the effects of THC (concentration) interact with personal factors (way of smoking, health status, alcoholism or medication). However, it is likely that the same THC concentration does not have the same effect on all smokers, which moreover tend to be confirmed by the plasticity of cannabis in the hormonal stream (see below).

---

[41] This section is based to a large extent on the INSERM 2001 report as well as the European scientific report 2002 and the survey work done by Wheelock 2002 for the Committee.

[42] INSERM (2001) *Cannabis. Quels effets sur le comportement et la santé?* Paris: author, page 340.

Δ^9THC is highly lipophilic and is quickly distributed to all fatty tissues, including the brain. It is also characterized by an entero-hepatic cycle and renal reabsorption which results in persistent effects. In a driving simulator study, a significant linear correlation was found up to seven hours following absorption, particularly on the trajectory control.

Δ^9THC undergoes oxydative metabolism resulting in the production of various elements, in particular 11-hydroxy-tetrahydrocannabinol (11-OH Δ^9THC) a psychoactive metabolite which, transported by albumin, whereas Δ^9THC attaches mainly to lipoproteins, penetrates the brain more deeply than Δ^9THC; 8 β-hydroxy-Δ^9-tetrahydrocannabinol, potentially psychoactive but whose action would be negligible; and various other components not known for their psychoactive effects. In addition to the potentially psychoactive elements, cannabis contains approximately 200 derivatives of combustion and pyrolysis comparable to those found in tobacco, though some of which are highly carcinogenic and are more concentrated in cannabis smoke than tobacco smoke.

Cannabinoids are eliminated in various ways: through digestion, the kidneys and perspiration. Approximately 15% to 30% of Δ^9THC in the blood is eliminated in urine, 30% to 65% through stools. Because it binds strongly to tissues, Δ^9THC is eliminated slowly in urine: the urine of regular heavy users contains traces of Δ^9THC-COOH 27 days after they have last used cannabis.

Regular users metabolize Δ^9THC up to twice as fast as individuals who have never previously used the drug. One study showed, in particular, that the intravenous administration of one 5 mg dose of Δ^9THC resulted in higher blood levels in regular users than occasional users.[43]

Cannabinoids act on the body through the endogenous cannabinoid system, consisting of neurochemical substances (endogenous ligands) and specific receptors. The behavioural and central effects of cannabis are due to the agonistic action of its main ingredients (in particular Δ^9THC, exogenous cannabinoid), on the endogenous cannabinoid receptors (anandamide, 2-arachidonoylglycerol) present in the nervous tissues of the brain.

Although the chemical structure of Δ^9THC was identified by Mechoulam in 1964,[44] it wasn't until very recently that the characteristics and location of the endogenous cannabinoid system was determined.[45] Two types of cannabinoid receptors have been isolated: CB1 in 1990[46] and CB2 in 1993.[47] CB1 is mainly expressed in the

[43] Cited in INSERM (2001) *op. cit.*, page 148.
[44] Guoli and Mechoulam (1964) *op. cit.*
[45] Devane, W.A. *et al.* (1992) "Isolation and structure of a brain constituent that binds to the cannabinoid receptor", *Science*, 258 (5090): 1946-1949.
[46] Matsuda, L.A. *et al.* (1990) "Structure of a cannabinoid receptor and functional expression of the cloned DNA", *Nature*, 346(6284) 5561-564.

central and peripheral nervous system. CB2 is expressed essentially in the cells of the immune system. It follows from this distribution that CB1 is essentially involved in psychotropic effects and CB2 in immunomodulatory effects.

The main endocannabinoids are arachidonoylethanolamide (also called anandamide - a word derived from Sanskrit, literally meaning congratulated) and 2-arachidonoylglycerol (2-AG). These are the only two endogenous molecules known to be capable of binding to cannabinoids receptors CB1 and CB2 and replicating the pharmacological and behavioural effects of Δ^9THC. Anandamide levels in the brain are comparable to those of other neurotransmitters such as dopamine and serotonine. The highest levels corresponding to high CB1 density areas, that is to say the hippocampus, striatum, the cerebellum and the cortex. Like anandamide, 2-AG reproduces all the behavioural effects of Δ^9THC or anandamide, but its action is less powerful.

The CB1 receptors are among the most abundant neuronal receptors in the central nervous system, and their distribution correlates remarkably with the behavioural effects of cannabinoids on memory, sensory perception and control of movements, as shown in the table below.

Location of CB1 receptors in the CNS and correlated pharmacological effects [48]

Structures	Marking	Physiological consequences	References
Forebrain			Herkenham et al., 1990
Amygdala	+		Herkenham, 1992
Olfactory systems	+		Tsou et al., 1998, 1999
Cerebral cortex	++	Cognitive effects	Katona et al., 1999
Basal nuclei	++	Locomotive effects	Rinaldi-Carmona et al., 1996
Hippocampus	++	Cognitive effects (short-term memory inhibition) and antiepileptic action	Matsuda et al., 1990, 1993 Hohmann, 1999
Thalamus/hypothalamus	+	Endocrine and antinociceptive effects	Marsiaco and Lutz, 1999 Westlake et al., 1994
Midbrain	-		
Grey nucleus	-		
Colliculi	-		
Optic nuclei	-		
Black substances/ventral tegmental area			
Hindbrain			
Grey periaqueductal area	+	Antinociceptive effects	
Locus ceruelleus	-		
Raphe	-		

[47] Munro, S. *et al.* (1993) "Molecular characterization of a peripheral receptor for cannabinoids", *Nature*, 365: 61-65. Note that a recent scientific conference of the National Institute on Drug Abuse in the United States reported on the work of researchers on the hypothesis that there are additional receptors and other ligands. To our knowledge, the latter have not yet been formally identified in the research setting.

[48] Table reproduced from INSERM (2001), *op. cit.*, page 298.

Structures	Marking	Physiological consequences	References
Bridged nucleus	-		
Brainstem	-	No lethal dose, no acute mortality	
Cerebellum	++	Motor effects (balance)	

++: abundant marking; +: intermediate marking; -: little or no marking.

This concentration of CB1 receptors largely explains the effects of Δ^9THC. Intense expression of CB1 receptors in the basal nucleus and molecular layer of the cerebellum is thus consistent with the inhibiting effects of cannabinoids on psychomotor performance and motor coordination. Their expression in the cortex and hippocampus is consistent with the modulation of elementary forms of learning, explaining in particular the reversible deleterious effects on short-term memory and cognitive function. Their lack of marking in the brainstem explains the absence of acute toxicity or lethal doses of cannabis derivatives. The CB1 receptors in the thalamocortical system participate in the sensory disturbances and analgesic properties of cannabis. Similarly, the presence of receptors in the periaqueductal area and the dorsal horn of the spinal cord contribute to its antinociceptive power.

We also note that the CB1 receptors do not merely inhibit brain function. As a result of circuit effects, cannabinoids can stimulate certain neuron populations, in particular dopaminergic cells in the mesolimbic pathway. Together with the observation that prolonged treatment with cannabis (at doses corresponding to the equivalent of 575 cannabis cigarettes a day!) appears to induce lasting adaptive changes to the central nervous system and to the positive relationship between cannabinoids and stress hormones (corticotrophine), this explains the difficulties (irritability, sleep disorders and so on) observed in regular users when they have stopped using cannabis. We return to this issue in the Chapter 7 in the discussion on cannabis tolerance and dependence.

Lastly, recent works suggest there are significant interindividual variations in the effects of cannabinoids depending on sex steroid hormones in men and women: it appears that the effects of exogenous and endogenous cannabinoids can be modulated by the hormonal state of each individual and that, in exchange, the CB1 receptors and endocannabinoids are able to regulate hormonal activity.

As was observed in the WHO report in 1997, various research questions remain unanswered, in particular how and to what extent cannabis use alters the endogenous cannabinoid and what the relationship is between blood plasma cannabinoid levels and induced behavioural effects.

CONCLUSIONS

In conclusion, the Committee makes the following findings:

	Conclusions of Chapter 5
On production	➢ The size of the cannabis market is estimated at 800 tonnes a year. ➢ The size of the national production has significantly increased, and it is estimated that 50% of cannabis available is now produced in the country. ➢ The main producer provinces are British Columbia, Ontario and Quebec. ➢ Estimates of the monetary value of the cannabis market are unreliable. For example, if 400 tons are grown yearly in Canada, at a street value of $225 per ounce, the total value of the Canadian production would be less than $6 billion per year, less than the often quoted value of the BC market alone. ➢ An unknown proportion of national production is exported to the United States. ➢ A portion of production is controlled by organized crime elements.
On THC	➢ THC is the main active ingredient of cannabis; in its natural state, cannabis contains between 0.5% and 3% THC. ➢ Sophisticated growing methods and genetic progress have made it possible to increase THC content in recent years, but it is impossible to estimate the average content of cannabis available in the market; it is reasonable to consider that content varies between 6% and 31%. ➢ THC is fat soluble and readily spreads in the innervated tissues of the brain; it reaches a peak in the blood plasma in less than nine minutes and falls to approximately 5% after one hour. ➢ The body is slow to eliminate THC and inactive THC metabolites can be detected in urine up to 27 days after use in the case of regular users. ➢ Psychoactive effects generally last two to three hours and as many as five to seven hours after use.

CHAPTER 6

USERS AND USES:

FORM, PRACTICE, CONTEXT

Who uses cannabis? How do the patterns of use in Canada compare to those in other countries? In what context is cannabis used? Why? What populations are most vulnerable? What are the social consequences of cannabis, specifically on delinquency and criminal behaviour? Most important, what trajectories do cannabis users follow, specifically with respect to consumption of other drugs?

Partial answers to these questions, at the very least, are prerequisite to establishing policy on a substance. If the aim is to deter, one needs to know what is to be deterred and within what target group. If the aim is to help people for whom consumption poses a problem, one must have at least an idea of the composition and size of the group in question. And if one is looking for indications that a public policy reduces all use or at-risk use, then knowing the evolution of patterns of use within a population is a requisite.

In Canada, knowledge of patterns and contexts of cannabis use verges on the abysmal. In the early 1980s, the USA, the United Kingdom, and Australia introduced monitoring systems for the general population and the student population and use them as the basis of annual (USA) or biannual (United Kingdom and Australia) reports on trends. In the last five years, a number of European countries have introduced data collection systems as part of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Canada, by contrast, has carried out only two epidemiological general population surveys specific to drugs (1989 and 1994), and only some provinces conduct surveys of the student population, using different methods and instruments that preclude data comparison. Furthermore, everything suggests that few sociological or anthropological studies are conducted on the circumstances or context of illegal drug use (specifically for cannabis). At any rate, very little has been brought to our attention. The result is that our pool of knowledge on users and characteristics of use is lacking.

We have no explanation for this situation, at least no satisfactory explanation. In the 1970s, following up on the work done by the Le Dain Commission, Canada could have set up a trend monitoring system. In the 1980s, when Canada's Anti-Drug Strategy–to which the federal government allocated $210M over five years–was adopted, a data collection system could have been created. The fact that it wasn't could

be due to an absence of leadership or vision; a fear of knowing; the division of powers among levels of government; or the absence of a socio-legal research tradition within the departments responsible for justice and health. In fact, all of the above are probable factors. Whatever the case, it is our contention that the situation, unacceptable by definition, requires timely remedial action. We must resign ourselves to working with the scarce available data, and more significantly the virtually non-existent comparable data. We will also look at studies and data from other countries.

The chapter is divided into four sections. The first covers consumption patterns in the population as a whole and specifically in the 12-18 year age group and compares the patterns in various countries. The second section looks at what we know about reasons for and details on use, including origins and cultural differences. The third section deals specifically with cannabis user trajectories, including escalation. The fourth and last section covers the relationship between cannabis use and delinquency and crime.

PATTERNS OF USE

Epidemiological surveys are the main method of measuring consumption patterns. These surveys cover the general population (usually 15 years of age and over) and specific populations, usually students. Most epidemiological surveys of the general population are done by telephone and based on a validated questionnaire. Personal interviews are involved in some cases. Some surveys of students are based on a questionnaire distributed in class.

Due to the low consumption of illegal drugs by the population as a whole, samples must necessarily be large (in Canada over 12,000 respondents). Whatever the sample size, these surveys inevitably underestimate consumption. Respondents tend to under-report, either because individuals simply refuse to respond because of the legal implications, or because some at-risk persons are not included in a telephone survey. Then there is the matter of memory: the more time elapsed between consumption and the survey, the less reliable one's memory of occasions, circumstances, and quantities.

Furthermore, some reports, including the report by the French National Institute for Health and Medical Research (INSERM) and the *Canadian Profile* of the Canadian Centre on Substance Abuse (CCSA), use data on police and customs seizure as indirect indicators of use. We have opted to discuss data on seizures and other police and customs activities in Chapter 14. In our opinion, these data, rather than accurately reflecting use, are indicators of police drug-related activities and to some extent, market conditions.

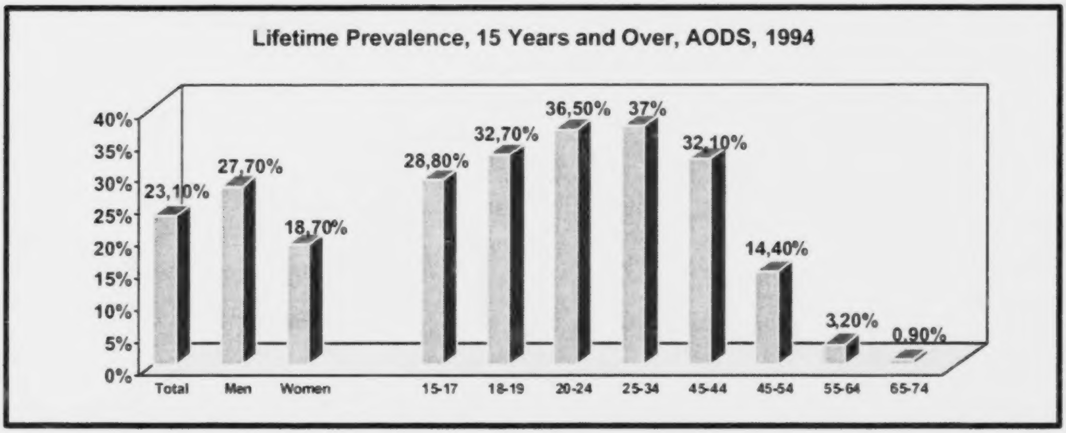
Not all surveys measure phenomena in the same way, although, in the past two years, significant strides have been made toward improving data comparability. Generally speaking, lifetime prevalence (minimum one time consumption) is measured.

This episodic or experimental consumption is distinguished from consumption within the previous year. Frequent consumption (e.g., within the past month) is less frequently measured. Heavy users are even more rarely studied. Furthermore, regular consumption tends to be measured in terms of dependency criteria - described in detail in the following chapter - rather than quantity-related indicators. As described in greater detail later in this chapter, this makes it difficult to distinguish among categories of users, specifically at-risk users and heavy users. Such information is essential to identifying target groups for preventive measures.

Consumption by the population as a whole

In Canada, five national surveys are the sources of data on consumption of psychoactive substances, alcohol, tobacco, and illegal drugs. The Health Promotion Survey (HPS) was conducted in 1985 and 1990; the Alcohol and Other Drugs Survey (AODS) in 1989 and 1994. The 1993 General Social Survey (GSS), a survey conducted on a regular basis, includes drug-related data. These are the data referred to in the following paragraphs.

In the 1994 survey, 23% of respondents reported consuming cannabis at least once in their lifetime. As shown in the bar graph below, men are more likely than women to have consumed cannabis, as are persons under 35 years of age.



Consumption varies by province. According to the AODS, consumption is highest in British Columbia (35.4%), followed by Alberta (29.4%), Manitoba (25.2%), Nova Scotia (25.1%) and Quebec (24.7%); and lowest in Newfoundland (16.3%), Ontario (16.6%) and Prince Edward Island (18.6%).

Lifetime prevalence was unchanged from the 1989 study. At the time of the Le Dain Commission, in 1970, the figure stood at 3.4%; by 1978 it was up to 17%, showing a steady increase in cannabis consumption.

Prevalence over the previous twelve months is a more sensitive indicator of current consumption as reporting is less dependant on long-term memory. The following table shows the evolution of this indicator beginning with the 1985 study.

Cannabis consumption in the last 12 months, 15 years and over[1]

Year	Survey	Sex		
		Men	Women	Total
1985	Health Promotion Survey	6.9%	4.3%	5.6%
1989	National Alcohol and Other Drugs Survey	8.9%	4.1%	6.5%
1990	Health Promotion Survey	7.0%	3.0%	5.0%
1993	General Social Survey	5.9%	2.5%	4.2%
1994	National Alcohol and Other Drugs Survey	10.1%	5.1%	7.4%

By comparison, the percentage of users in the last year was 1% in 1970 and 9.7% in 1979.

The rate of use reported in these surveys is twice as high for men as for women. It is important to note the variations among studies. Because the AODS deals specifically with psychoactive substances, rather than being part of a broader survey of health or living conditions, it would appear to be more reliable.

We have no detailed data on incidence (i.e., new consumers) or rate of discontinuation. As will be seen further on, rising prevalence among young people would indicate increased incidence. With respect to discontinuation, it is generally believed that the vast majority of users do not continue using, although we are lacking specific information in Canada on this issue.

We are aware that there are limitations to comparing the various psychoactive substances. As properly pointed out by Dr. Zoccolillo in his testimony, each has its own characteristics and effects.

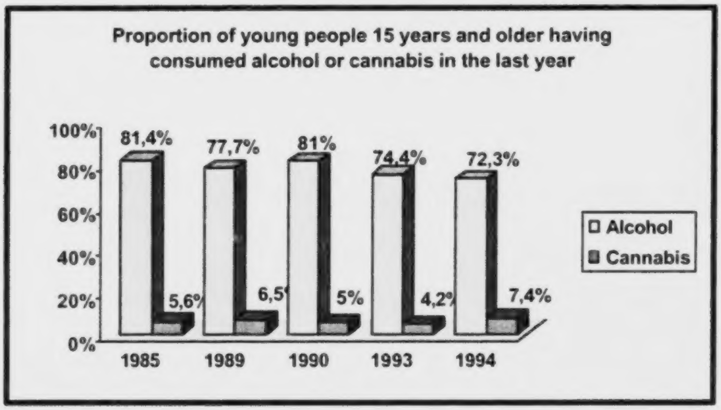
> *There is little point in comparing the levels of harm from cocaine, marijuana and alcohol. Each drug has specific kinds of harm. If you were to compare the effects of tobacco and cocaine in young people, you would conclude that cocaine is terrible but tobacco is not worth worrying about, because the harm from*

---

[1] Table reproduced from CCSA-CAMH (1999), *Canadian Profile. Alcohol, tobacco and other drugs. Ottawa: author*, page 142.

tobacco takes 30 years to appear. The point is that there are different patterns of harm and making comparisons among them is not a useful exercise. [2]

Nonetheless, to place the phenomenon in context, we believe it is valid to compare Canada's consumption of cannabis in the general population to consumption of other substances. The 1994 Alcohol and Other Drugs Survey shows that, of total illegal drug consumption, cocaine accounts for less than 1%, and heroin, LSD, and amphetamines together for approximately 1%. In the case of legal drugs, alcohol consumption is about 75%, tobacco approximately 30%. The accompanying graph compares consumption of cannabis and alcohol among those over 15 years of age.



General population studies have been conducted in Ontario since 1977, giving the province the most extensive database in Canada. Of even greater interest, is the fact that Ontario (again since 1977) has conducted studies in schools. This practice provides for a better tracking of trends.

According to the 2000 report of the Centre for Addiction and Mental Health (CAMH)[3], more than one third (35%) of Ontarians over 18 years of age have consumed cannabis at least once in their lifetime and 10.8% within the last 12 months. The figure for users within the past year has changed little since 1984 (11.2%), although it is up slightly from the 1977 figure (8%). The 18-29 age group shows the steadiest increase, from 18.3% in 1996 to 28.2% in 2000; the 1984 figure for the cohort is 28.5%. In the long term, we also see an increase in consumption within the last 12 months in the 30-49 age group (from 6.5% in 1977 to 18.7% in 2000). The following table sets out selected data from the report.

---

[2] Testimony by Dr. Mark Zoccolillo, Professor of Psychiatry and Pediatrics, McGill University and Montreal Children's Hospital, Special Senate Committee on Illegal Drugs, second session of the thirty-sixth Parliament, October 16, 2000, Issue 1, page 80.

[3] Adlaf, E.M. and A. Ialomiteanu (2000) *CAMH Monitor Report: Addiction and Mental Health Indicators among Ontario Adults, 1977-2000.* Toronto: Centre for Addiction and Mental Health, pages 61-67.

Proportion of Ontarians 18 years old and over using cannabis users in the previous 12 months

	1977	1982	1984	1987	1989	1991	1992	1994	1996	1997	1998	1999	2000
(N =)	(1059)	(1026)	(1043)	(1075)	(1098)	(1047)	(1058)	(2022)	(2721)	(2776)	(2509)	(2346)	(2406)
Total	8.1	8.2	11.2	9.5	10.5	8.7	6.2	9.0	8.7	9.1	8.6	10.4	10.8
M	11.2	12.3	15.6	12.3	13.0	11.5	9.1	11.4	12.6	11.4	12.1	13.2	14.3
W	4.5	4.1	7.1	6.8	8.2	6.0	3.6	7.0	5.3	7.0	5.4	7.8	7.7
18-29	22.6	22.7	28.5	20	24.6	19.9	13.3	19.6	18.3	21.4	25.2	27.1	28.2
30-39	3.9	4.2	9.5	11.6	11.8	9.1	6.6	10.2	11.3	9.8	8.2	10.3	12.3
40-49	2.3		2.2	5.4	3.9	3.0	2.4	4.3	6.1	4.3	4.	6.8	6.4
50-64	1.2	1.3	1.8		1.4		1.3			1.7	1.4	4.1	2.9
65+													

Of those who consumed cannabis at least once in their lifetime, 68% did not consume within the last 12 months, 15% consumed less than once a month, and 17% more than once a month. Of users within the last year, 47% consumed less than once a month and 53% at least once a month.

In Quebec, general population studies were done in 1987, 1992, and 1998. *L'enquête sociale et de santé* (ESS)[4] reports that 31.3% of people 15 and over used cannabis or another illegal drug at least once in their lifetime, and 13.5% had consumed cannabis at least once in the past few months. As elsewhere, consumption is a function of age: in the 15-24 age group, consumption of illegal drugs is 39.7%; it is 18.4% in the 25-44 age group, 8% in the 45-64 age group, and 5.5% in the 65 plus age group. Although 83.7% of the 45-64 age group and 93.8% of the 65 plus age group report never having used a prohibited drug, over 40% of the 25-44 age group and half (50.3%) of the 15-24 age group report current or past consumption.

Consumption among young people

A number of witnesses have reported "worrying" increases in cannabis consumption among young people (under 18).

> *Given the existing research on the escalating rates of cannabis use in the general population of young people, our street youth and our youth at risk, coupled with knowledge about the harms associated with drug use, we know that our problem is growing.* [5]

---

[4] Chevalier, S., et O. Lemoine (2000) « Consommation de drogues et autres substances psychoactives. » in *Enquête sociale et de santé 1998*, Québec : Institut de la Statistique du Québec, chapter 5, page 137.

[5] Testimony of M.J. Boyd, Chair of the Drug Abuse Committee and Deputy Chief of the Toronto Police Service, Canadian Association of Chiefs of Police, Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, March 1, 2002, Issue 14, page 77.

Special consideration needs to be given to minors when developing drug policy. A policy created only with adults in mind may have strong, unintended negative consequences for adolescents. We have a parental obligation to adolescents. They are not adults. [6]

The Ontario students survey is equally disconcerting. A dramatic upswing is noted in the use of all drugs since 1993.(...) The use of cannabis has more than doubled to 29 per cent.(...) Unfortunately, the only statistic that has decreased is the one that records the students who do not use drugs. That figure has decreased from 36 per cent to 27 per cent. From almost one-third of the students not using drugs, we now have almost a one-quarter of the students not using drugs. We are clearly in a time where young people are turning to drugs as an answer to life's problems. [7]

It is a fact that consumption of psychoactive substances by young students has increased significantly in the past several years. Nationally, the survey conducted among Grade 6, 8, and 10 students (approximately 2,000 young people in each grade) in 1990, 1994, and 1998[8], reports the following with regard to marijuana use:

Proportion of Grade 8 and 10 students who have consumed cannabis at least once

	1990	1994	1998
Grade 8			
girls	10%	11%	18%
boys	11%	13%	21%
Grade 10			
girls	24%	27%	41%
boys	26%	30%	44%

Surveys on consumption of psychoactive substances, including cannabis, among young people have been conducted in some provinces. These give a clearer and more detailed picture of the evolution of cannabis consumption among young people in those provinces, although the results cannot be compared from province to province.

Atlantic

In the Atlantic provinces (Newfoundland and Labrador, Prince Edward Island, Nova Scotia, and New Brunswick) identical comprehensive surveys on cannabis consumption by high school students were first conducted in 1996.[9] The process was

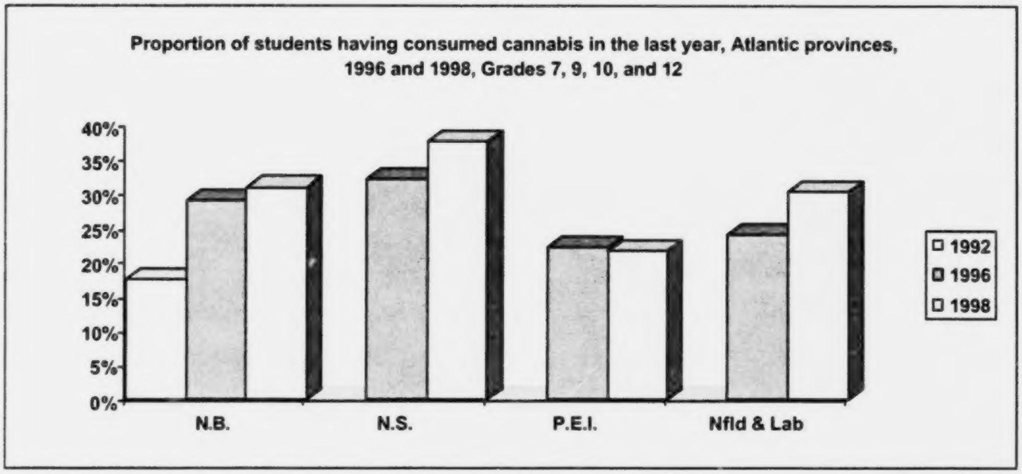
[6] Testimony of Dr. Mark Zoccolillo, *op. cit.*, page 77.

[7] Testimony of R.G. Lesser, Chief Superintendent, Royal Canadian Mounted Police, Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, October 29, 2001, Issue 8, page 9.

[8] King, A.J.C. et al., (1999) *Trends in the Health of Canadian Youth. Health Behaviours in School-Age Children.* Ottawa: Health Canada.

[9] New Brunswick conducted student population studies in 1986, 1989, and 1992.

repeated in 1998. The 1996 survey covered 14,908 students and the 1998 survey, 13,539 in grades 7, 9, 10, and 12.[10] The following graph illustrates the data from the two surveys and the 1992 reference year for New Brunswick.



Cannabis consumption among students in the Atlantic provinces rose from 28% in 1996 to almost 33% in 1998. The provincial trends follow.

❖ In Nova Scotia, between 1991 and 1998:

- The percentage of students using illegal drugs nearly doubled;
- The percentage of students reporting consumption of cannabis within the last year was close to 38% in 1998, compared to 32% in 1996;
- Distribution by school grade: 11.4% in Grade 7, 41% in Grade 9, 47.6% in Grade 10 and 51.7% in grade 12;
- The percentage of students using cannabis more than once a month tripled, from 4.4% to 13.5%; more men (17.5%) than women (9.3%) consumed cannabis once a month.

❖ In New Brunswick:

- The proportion of students reporting cannabis consumption climbed from 17.4% in 1992 to 29% in 1996 and 31% in 1998;
- Among cannabis users, 5.5% experimented during the year and 11% were frequent users (more than once a month);

[10] See http://www.gov.ns.ca/health/student-drug-use/contents.htm for Nova Scotia and http://www.gnb.ca/0378/en/sdus1998/index.htm for New Brunswick. A summary is also available on the CCSA's website at: http://www.ccsa.ca/Reports/STUDENT.HTM

- As in the other provinces, more men (33.4%) than women (28.3%) consumed cannabis.

By comparison, in 1996 56% of students in the Atlantic provinces reported consuming alcohol at least once during the last year; the corresponding figure for 1998 is 59%.

Manitoba

In Manitoba, a 2001 non-random survey of schools in the province was conducted among 4,680 students in 32 schools.[11] Although the sample is not completely representative of all students in Manitoba, it is sufficiently large to give a satisfactory representation of the situation in the province.

Virtually all students reporting consumption of illegal drugs in the course of the preceding year used marijuana (96%). 47.7% of students consumed it at least once in their lifetime, 39.7% in the course of the preceding year (compared to 37.4% in 1995 and 38.8% in 1997). The mean age of initial use is 14.1 years. More boys (40.4%) than girls (35.4%) consumed cannabis in the course of the preceding year. Of the users, 8.5% consumed it approximately once a month and 15.8% more than once a month (20.5% of boys and 11.2% of girls).

By comparison, 87.4% of students consumed alcohol at least once in their lifetime, and 80.4% at least once in the course of the preceding year. The mean age of first consumption is 13.3 years. Of those who consumed alcohol in the course of the preceding year, 26% reported consumption once or more weekly, 46.5% at least once a month. Weekly consumption rises with school grade, from 17% in the 1st year of high school to 33% in the 4th. Finally, 27.7% of students consumed cannabis, alcohol, and tobacco in the course of the preceding year.

Ontario

In Ontario, in the 2001 Ontario Student Drug Use Survey (OSDUS)[12] an average of 33.6% of young people in Grade 7 to Grade 13 report using cannabis at least once, and 29.8% in the past several months (the corresponding figures for tobacco are 33.8% and 23.6%; for alcohol 70.6% and 65.6%). Rate of use is significantly higher for boys than girls. Examination of changes in trends shows that, following a dip in the early 1990s, the results in the two most recent surveys are similar to those in the late '70s and early '80s.

---

[11] Patton, D., et al., (2001) *Substance use among Manitoba high school students.* Winnipeg: Addictions Foundation of Manitoba. Available at www.afm.mb.ca

[12] Adlaf, E.M. and A. Paglia (2001) *Drug Use among Ontario Students 1977-2001. Findings from the OSDUS.* Toronto: Centre for Addiction and Mental Health.

Proportion of Ontarians in grades 7 to 13 using cannabis in the previous 12 months

(N =)	1977 (4687)	1979 (4794)	1981 (3270)	1983 (4737)	1985 (4154)	1987 (4267)	1989 (3915)	1991 (3945)	1993 (3571)	1995 (3870)	1997 (3990)	1999 (2868)	2001 (2326)
Total	25.1	31.7	29.9	23.7	21.2	15.9	14.1	11.7	12.7	22.7	24.9	29.2	28.6
M.	29.4	36.4	33.2	28.0	24.4	18.7	14.7	13.2	14.8	25.7	25.7	32.5	32.1
W.	21.1	26.	26.3	19.4	17.9	13.2	13.5	9.9	10.7	19.8	24.1	25.8	25.1
7th	5.6	10.4	5.7	5.2	4.7	3.8	0.9	0.7	1.7	2.8	3.4	3.6	5.1
8th	-												
9th	23.2	29.2	27.1	25.1	18.3	12.1	12.9	8.1	8.7	19.6	23.9	25.5	28.8
10th	-												
11th	39.4	50.2	44.2	42.1	35.1	24.3	22.5	20.2	22.3	40.7	42.0	48.1	45.7
12th	-												
13th	42.4	43.6	37.4	36.5	30.8	30.5	28	20.5	21.6	27.5	31.9	43.3	43.9

Comparison of cannabis use trends to trends for other substances shows that:

- In the past 12 months, tobacco consumption fell from 30.4% to 22.3% of students;
- In the past 12 months, alcohol consumption fell from 76.3% to 62.6% of students;
- Heroin [heroine being a female hero] consumption slipped from 2.0% to 1.2%;
- Cocaine consumption remained steady at 3.8%;
- Amphetamine consumption edged up from 2.7% to 3.1%; and
- Ecstasy consumption shot up from 0.6% in 1993 (first inclusion) to 6.0% in 2001.

The Ontario survey examines frequency of consumption. Of those who used cannabis in 2001, 25% did so once or twice, 30% from 3 to 9 times, and 45% more than 10 times. Overall, 16.9% of students consumed cannabis at least 6 times in the course of the past 12 months. The following table illustrates the evolution of consumption frequency in the preceding 12 months (1981 base year).

Frequency of consumption in the preceding 12 months among users in Ontario[13]

	1981 (1002)	1983 (1304)	1985 (907)	1987 (701)	1989 (570)	1991 (515)	1993 (455)	1995 (873)	1997 (1019)	1999 (778)	2001 (636)
Freq.											
1-2	28.2	32.4	33.7	39.8	42.6	37.1	41.1	31.7	29.5	28.8	25.6
3-5	12.4	15.1	18.3	16.2	17.2	17.7	17.5	17.1	16.3	14.7	17.1
6-9	14.0	12.5	11.3	9.0	10.5	12.2	10.1	10.4	12.4	13.9	11.4
10-19	13.0	11.4	11.3	14.1	11.8	9.8	9.0	12.5	12.3	11.9	14.9
20-39	10.7	9.0	8.3	6.2	8.3	8.9	8.8	9.0	9.8	9.5	10.2
40 +	21.7	19.5	17.1	14.8	17.1	14.3	13.6	19.4	19.7	21.2	20.9

[13] Table reproduced from Adlaf and Paglia, *op. cit.*, page 57.

On a smaller time scale, the study looks at consumption over the past four weeks. Overall, 8.4% of students consumed cannabis weekly, and 3.1%, daily. The proportion of students who did not consume cannabis in the past month fell from 90.2% in 1987 to 66.6% in 2001.

The following table illustrates the evolution of monthly consumption among users over the preceding 12 months for the 1987-2001 time period. There is a marked reduction in the percentage of students who had used no cannabis in the past month (from 41% in 1987 to 30% in 2001) and, conversely, an increase in the number of students who used it daily (from 3.5% in 1987 to 9.1% in 2001).

Frequency of monthly usage among users in the preceding 12 months, OSDUS[14]

	1987 (701)	1989 (570)	1991 (515)	1993 (455)	1995 (873)	1997 (1019)	1999 (778)	2001 (636)
Never								
Total	41.1	46.0	44.1	37.2	30.9	33.0	30.5	30.6
Men	38.1	44.8	38.6	29.7	28.4	28.9	28.5	23.2
Women	45.3	47.2	51.8	47.5	33.8	36.9	33.0	39.8
1-2 times a month								
Total	36.6	38.3	34.5	36.9	35.7	34.2	34.8	33.2
Men	36.7	33.8	33.4	35.8	33.8	30.4	31.1	32.9
Women	36.4	42.9	36.0	38.1	37.9	37.9	39.4	33.6
1-2 times a week								
Total	9.7	9.6	7.9	9.9	14.4	13.7	12.5	11.3
Men	9.8	10.6	8.7	12.7	15.5	14.6	12.9	12.
Women	9.5	8.5	6.7	6.1	13.2	12.8	12.0	10.1
3-4 times a week								
Total	4.9	2.6	5.8	5.9	9.2	7.6	8.5	8.3
Men	4.6	4.8	8.5	7.4	9.4	10.2	10.2	9.9
Women	5.5	0.4	2.0	3.8	9.0	5.1	6.3	6.4
5-6 times a week								
Total	4.1	1.0	2.4	5.1	3.6	3.9	4.4	7.4
Men	5.3	1.9	3.2	7.5	4.4	4.5	5.9	7.5
Women	2.5		1.2	2.0	2.5	3.4	2.6	7.3
Daily								
Total	3.5	2.6	2.6	5.0	6.3	7.6	9.3	9.1
Men	5.6	4.1	4.1	6.9	8.6	11.4	11.3	14.3
Women	0.8	1.1	1.1	2.4	3.6	3.9	6.6	2.8

[14] *Ibid.*, page 58.

OSDUS also provides information on quantity consumed. Among 2001 users over the past 12 months, 15% smoked less than one joint, 21% approximately one, 22% two or three, and 15% more than four. The study also looks at the question of age at the time of first consumption. Again in 2001, 10.2% of students used cannabis for the first time, including 31.7% of cannabis users over the past 12 months. The age of initial use does not vary with sex or region, but is significantly linked to educational level: between Grade 8 and Grade 9 (14-15 years of age), the proportion of those who have smoked cannabis shoots up from 6% to 14.9%. Early initiation (Grade 7, approximately 12 years of age) to cannabis has fallen over the years: in 2001, 2% of Grade 7 students said they had used cannabis at least once in the preceding year (at about 11 years of age), a figure below those for 1997 (5%) and 1991 (8%).

Quebec

In Quebec, some observers report a "disturbing" increase in regular consumption of cannabis by young people. According to Michel Germain, Director of the CPLT, increased use is closely related to social values, specifically messages relating to a relaxed attitude to drug use, as opposed to socio-demographic factors such as family income or composition.

The data available are not directly comparable to those collected in Ontario. They come from three general population surveys conducted by *Santé Québec* in 1987, 1992, and 1998 and cover the 15-24 year age group. Respondents numbered 3,136, 3,912, and 3,587 respectively, and were divided into three age groups (15-17, 18-19, and 20-24).[15]

At first glance, the study reveals a statistically significant drop between 1987 and 1998 in the number of young people who report no drug consumption (71.3% in 1987, 57.4% in 1992, and 50.3% in 1998). The figures for "current" consumers (last 12 months) are 39.7% for 1998 and 27% for 1992. By age group, the increase in illegal drug consumption (significant in each case to $p < .001$) is as follows:

- 15 – 17 years: 26.2% to 37.6%
- 18 – 19 years: 28.1% to 41.6%
- 20 – 24 years: 26.2% to 40.3%

Among drug users, the percentage of those who use marijuana exclusively climbed from 15% in 1992 to almost 26% in 1998, whereas the proportion of those who use other drugs remained steady at approximately 13%.

[15] Vitaro, F, Gosselin C. and A. Girard (2002) *Évolution de la consommation d'alcool et de drogues chez les jeunes au Québec de 1987 à 1998: constatations, comparaisons et pistes d'explication.* Montréal: Comité permanent de lutte à la toxicomanie.

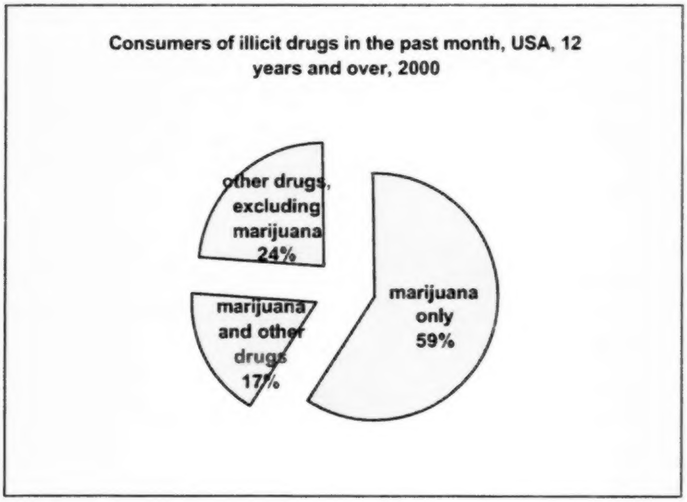
Use patterns in other countries

Obviously, use patterns are not immediately comparable from one country to another, not only because of cultural differences but because the systems for collecting data on use patterns do not all measure the same things in the same way, or even for the same time period. In Europe, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is gradually working toward uniformization of data collection in the various countries of the Union with a view to improving comparability. Nonetheless, significant differences among countries remain.

In spite of these reservations, it is interesting to compare use patterns among the various countries. We will begin by looking at the situation in the United States, the United Kingdom, France, and the Netherlands, and then attempt to compare some of the indicators selected.

United States

In the United States, two major surveys have been conducted for a number of years: a general population survey conducted by the Department of Health and Social Services, and the University of Michigan *Monitoring the Future* study of cohorts of graduates conducted for the *National Institute on Drug Abuse* (NIDA).



The 2000 general population survey[16] shows that 6.3% of Americans 12 years and over used illegal drugs during the past month, and 4.8% (4.7% in 1999) consumed cannabis. Overall, 14 million Americans are considered *current users* of illegal drugs, i.e., consumers in the past month. Among this group of users, 76% are consumers of marijuana and 59% of marijuana only.

The estimated number of new users in 1999 was 2 million, compared to 2.6 million in 1996 and 1.4 million in 1990. Two thirds of the new consumers were between 12 and 17 years of age, the others in the 18-25 age group. Average age at the first experiment with cannabis was 17 in 1999, compared to about 19-20 at the end of the 1960s.

[16] Substance Abuse and Mental Health Services Administration (2001) *Summary of findings from the 2000 national household survey on drug abuse.* Washington, DC: Department of Health and Social Services

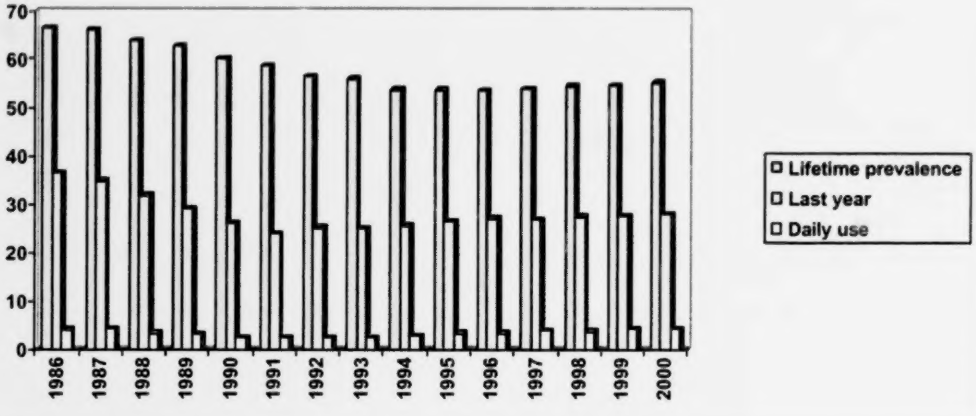
Frequency of consumption among current users increased between 1999 and 2000: in 1999, 31.6% consumed cannabis 100 days or more during the preceding year, compared to 34.7% in 2000. Finally, the distribution by age group follows the expected trends, as shown in the following chart.

Cannabis consumption in the last month,1999 and 2000, USA, by age group

	12-13	14-15	16-17	18-25	26+
■ 1999	1.50%	6.90%	13.20%	14.20%	2.80%
□ 2000	1.10%	6.90%	13.70%	13.60%	3.00%

The *Monitoring the Future* 2000[17] survey gives use patterns beginning in 1986 for cohorts of young graduates between 19 and 32 years of age. The following figure summarizes the data.

Lifetime prevalence, use in the last year and daily use, 19-32 years of age, USA, 1986-2000



[17] Johnston, L.D., et al., (2001) *Monitoring the future. National Survey Results of Drug Use, 1975-2000. Volume II College Students and Young Adults Ages 19-40.* Bethseda, Michigan: NIDA.

In 2000, lifetime prevalence in the 31-32 age group was 73% for all illegal drugs, 68% for marijuana.

United Kingdom

In the United Kingdom, the *British Crime Survey*[18] has measured illegal drug use patterns every two years since the early 1980s. Since establishment of the EMCDDA, *Drugscope,*[19] the United Kingdom correspondent, annually reports use patterns and related indicators.

The percentage of respondents between the ages of 16 and 59 who consumed an illegal drug during the last year in the United Kingdom rose from 9.9% in 1994 to 10.7% in 2000. The figures for cannabis are 8.4% and 9.4% respectively. Lifetime prevalence of cannabis use in the 16-29 age group climbed from 34% in 1994 to 44% in 2000. As a function of age, the use patterns over the last year are as follows:

- 16-19 years of age: from 29% in 1994 to 25% in 2000;
- 20-24 years of age: from 23% in 1994 to 27% in 2000;
- 25-29 years of age: from 12% in 1994 to 17% in 2000.

In all instances, consumption by men is greater than consumption by women.

The report notes that the most significant change is in consumption of cocaine by young men in the 16-29 age group (up from 1.2% to 4.9%).

France

The work of the *Observatoire français des drogues et de toxicomanies* (OFDT) [French monitoring centre for drugs and drug addiction] has greatly improved monitoring and understanding of trends in France. The OFDT publishes a bi-annual report on use patterns and related indicators (e.g., seizures, enquiries, applications for treatment) and a series of studies and technical reports on specific issues. In its 2002 report, the OFDT[20] gives the following figures on cannabis consumption:

- Lifetime prevalence: 21.6% of adult population (18-75)
- Occasional use (at least once in the past year): 6.5%
- Repeated use (at least ten times within the past year): 3.6%
- Regular use (ten times per month and over): 1.4 %

---

[18] The 1998 and 2000 reports are available on-line at the Home Office website: http://www.homeoffice.gov.uk/rds/pdfs/hors224.pdf

[19] The 2000 report is available on-line at the following website: http://www.drugscope.org.uk/wip/11/3/pdf/UK%20DRUG%20SITUATION%202001.pdf

[20] Observatoire français des drogues et de toxicomanies (2002) *Drugs and Drug Addiction: Indicators and Trends 2000.* Paris: author, pages 98-99.

More than twice as many men as women experiment with marijuana; in the 18-34 age group, 40.5% of men have tried it. The proportion of experimenters drops with age. Repeated consumption is reported by 14.6% in the 18-25 age group, compared to 1.6% in the 26 and over age group. The OFDT reports that the percentage of the adult population (18-34 age group) who have experimented with cannabis continues to rise due to increased "trivialization" of cannabis. Among adolescents, consumption has risen significantly. In 1993, 34% of boys and 17% of girls reported having consumed cannabis by the age of 18, compared to 59% and 43% respectively in 1999. The OFDT report goes on to say that experimentation with cannabis has become standard behaviour for young people in late adolescence.

Interestingly enough, the OFDT report allows for construction of a user typology and, without too great a stretch, identification of the warning signs of possible at-risk behaviour.

The following table shows frequency of consumption among young people in late adolescence.[21] In addition to the differences according to sex found in other epidemiological surveys, this table shows that fewer than one quarter of 17 year-old boys report occasional use, compared to one third of 19 year-olds. At the same time, the figure for boys, between the ages of 17 and 19, who abstain drops by 10 points.

Frequency of cannabis consumption by young people in late adolescence in 2000, by age, sex and type of consumption

Type of consumption	Definition	Girls, 17 yrs	Boys, 17 yrs	Boys, 18 yrs	Boys, 19 yrs
Abstinence	Never	59.2	49.9	45.1	39.8
Experimental	Past consumption, but not in the last year	5.0	5.4	6.5	8.2
Occasional	Between 1 and 9 times a year	23.3	20.9	19.9	19.4
Repeated	More than 9 times a year, less than 10 times a month	7.4	9.3	9.9	10.1
Regular	Between 10 and 19 times a month	2.6	6.4	6.2	6.8
Intensive	20 times or more a month	2.	8.0	12.4	15.8

The other interesting breakdown in the OFDT study–one that points to potential problems (and could be useful for preventive purposes) even though the report makes it clear that no equivalence was made between these profiles and risk–concerns circumstances of use. A separate category is created for those who smoke alone or in

[21] *Ibid.*, page 100.

the morning or at noon. A near-perfect linear relationship can be seen between type and circumstances of use, as shown in the table below.[22]

Frequency of cannabis use, in the morning or alone, by young people in late adolescence, in 2000, by type of consumption

Type of use	Morning or noon			Alone		
	Never	Occasionally	Often	Never	Occasionally	Often
Occasional	57.2	40.4	2.4	81.9	16.2	1.9
Repeated	17.9	69.8	12.3	46.4	46.6	7.0
Regular	4.7	58.9	36.4	19.9	60.2	19.8
Heavy	1.1	22.7	76.1	4.5	38.2	57.3

The situation was explained by Jean-Michel Coste, Director of the Monitoring Centre in his testimony to the Committee:

I think it is extremely important to answer the concerns of authorities when, in matters of prevention, those authorities are looking for something whose objective is not only to prevent first use, but also to prevent going from regular use to use that turns into a problem. From the investigation point of view, it is important to define this idea of problematic use and grade the users. It is possible to do this by trying to find occasional users, those who use repeatedly or regularly and those who constitute a problem.

Right now, we are trying to define three user criteria. We are trying to see if the young person uses cannabis on an intensive or daily basis, if he often uses alone or uses often in the morning. If we get a combining of those three criteria, I think we can define something covering the notion of problematic use of cannabis.[23]

The Netherlands

The Netherlands is a country of particular interest because of the unique approach it adopted in 1976.[24] An epidemiological survey of use patterns of the general population was conducted in 1997; the results of a second (2001) survey are expected soon. For individuals between the ages of 15 and 64, the data show a lifetime prevalence of 19.1%, consumption in the preceding year of 5.5%, and consumption within the past month of 2.5%. First-time users in the preceding year account for 1% of the population, and average user age is 28. In the 15-34 age group, lifetime prevalence is 31.8% and use within the last year, 14.2%.

[22] *Ibid.*, page 101.

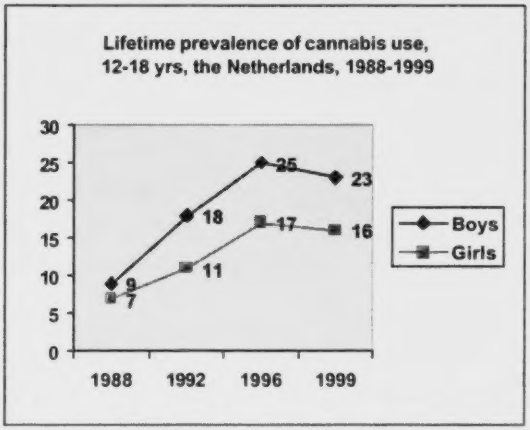
[23] Mr. Jean-Michel Coste, Director, *Observatoire français des drogues et des toxicomanies*, testimony given before the Special Senate Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, October 1, 2001, Issue 7, pages 31-32.

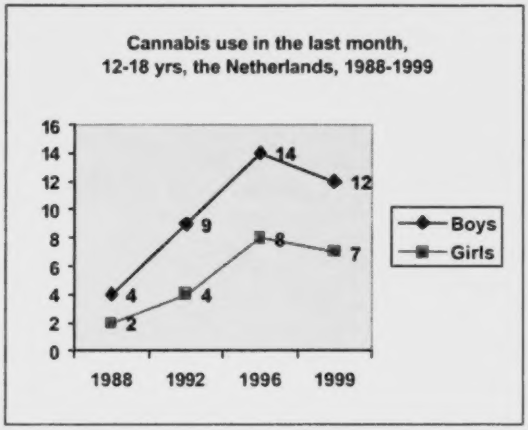
[24] Chapter 20 discusses public policy approaches in various countries in greater detail.

Among recent users (within the past month), frequency is distributed as follows:

- Consumption on 1 to 4 days during the course of the month – 45%
- Between 5 and 8 days – 14%
- Between 9 and 20 days – 15%
- Over 20 days – 26%

In addition, since 1984, the Netherlands has conducted surveys of students between the ages of 10 and 18. The data produced show a significant increase in lifetime use and current use (past month) as in the following charts (data for 12-18 age group only). [25]





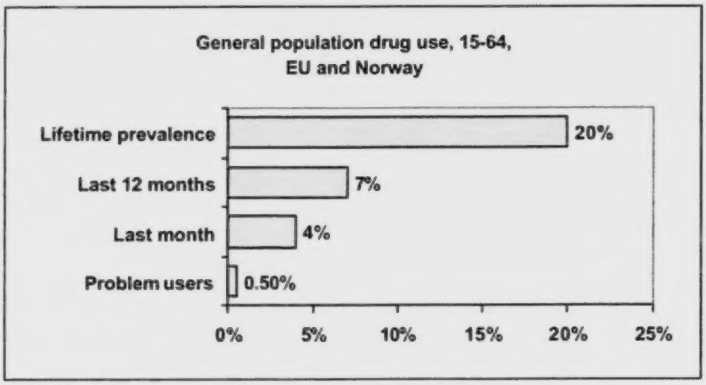
As in the other studies, more boys than girls are consumers and prevalence increases with age: in the 16-17 age group, lifetime prevalence for boys is 43%, for girls 31%, with current use figures 22% and 11% respectively.

Use patterns in Europe, ages 15-64

EMCDDA publications covering Europe and Norway reveal an interesting gradation in the nature of illegal drug use. Although the table shown here covers all illegal drugs, we know that cannabis is the drug of choice for at least 90% of users in all countries. The table is relevant here because we will be attempting to estimate proportions of users in Canada by cannabis use.

[25] Trimbos-Instituut (2000) *The Netherlands Drug Situation 2000*. Report to the EMCDDA. Available on line at: http://www.emcdda.org/multimedia/publications/national_reports/NRnetherlands_2000.PDF

In other words, of the approximately 50 million people who have experimented with an illegal drug at least once in their lifetime, approximately 17.5 million have used drugs in the preceding 12 months, 10 million, in the past month, and 0.5% are considered at-risk users.



International comparisons

In spite of significant differences in survey methods (type of questionnaire and form of entry), indicators, years and age range covered, the following tables provide valuable indications of prevalence in a group of countries.

The first table sets out information on year of survey, age of respondents, and proportions reporting prevalence of cannabis consumption in their lifetime and in the last year. For purposes of comparison, we have added the most recent Ontario data on the general population.

Lifetime prevalence and consumption in the last year, general population [26]

Country	Year	Form of entry	Sample	Age	Lifetime prevalence	Last year
Australia	1998	Mixed	10,000	14+	39%	18%
USA	1999	Mixed	66,706	12+	35%	9%
USA	2000	Mixed	71,764	12+	34%	8%
U.K.	2000	Mixed	13,021	16-60	27%	9%
Denmark	2000	In person	14,228	16-65	24%	4%
France	1999	Telephone	11,526	15-65	23%	8%
Belgium	1998-1999	Telephone	3,311	18-50	21%	?
Germany	2000	Mail	6,332	18-60	21%	6%
Ireland	1998	Mail	10,415	15-65	20%	9%
Spain	1999	In person	12,488	15-65	20%	7%
Netherlands	1997	In person	22,000	15-65	19%	6%
Switzerland	1997	Telephone	13,004	15-60	19%	5%
Greece	1998	In person	3,752	15-65	13%	4%
Sweden	2000	In person	2,000	15-65	13%	1%
Germany (East)	2000	Mail	1,430	18-60	11%	5%
Finland	1998	Mail	2,568	15-70	10%	3%
Ontario	2000	Telephone	2,406	18 +	35%	10.8%

[26] Table adapted from Rigter, H. and M. von Laar (2002) "The Epidemiology of cannabis use." in Pelc, I. (ed.), *International Scientific Conference on Cannabis*. Brussels.

Lifetime consumption prevalence is 10% in Finland compared to 39% in Australia; consumption in the preceding year in Sweden is only 1%, in Australia, it is 18%. The Ontario figures of 35% and 11% respectively are among the highest cannabis consumption figures reported.

The second table is specifically about young people.

Prevalence of consumption by young people, 15-16 years old, 1995 and 1999[27]

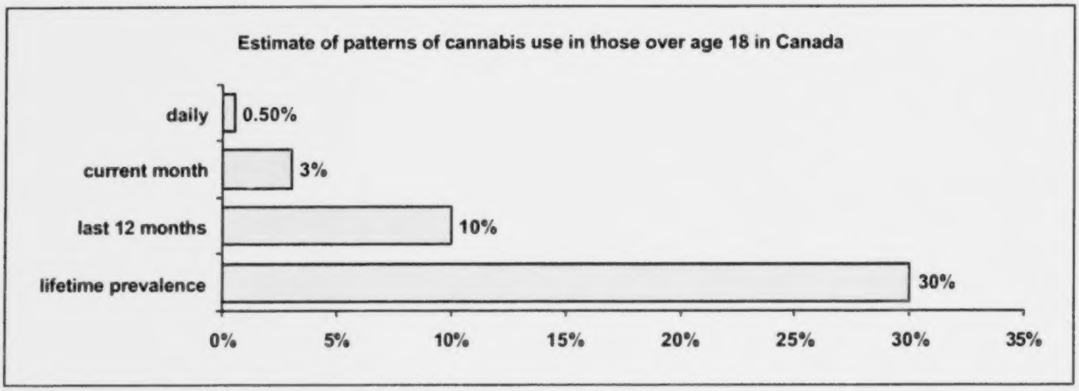
Country	Lifetime prevalence		Last month		> 6 times in the last month	
	1995	1999	1995	1999	1995	1999
USA	34%	41%	16%	19%	7%	9%
Russia	41%	35%	24%	16%	9%	6%
France	-	35%	-	22%	-	9%
Ireland	37%	32%	19%	15%	7%	5%
Netherlands	29%	28%	15%	14%	6%	5%
Italy	19%	25%	13%	14%	5%	4%
Denmark	17%	24%	6%	8%	1%	1%
Norway	6%	12%	3%	4%	1%	1%
Finland	5%	10%	1%	2%	0%	1%
Greece	2%	9%	1%	4%	0%	2%
Portugal	7%	8%	4%	5%	1%	2%
Sweden	6%	8%	1%	2%	0%	0%

We lack readily-comparable data for Canada. Returning to the Ontario data, we see that, in 1995, 40.7% of Grade 10 students had consumed cannabis at least once in the preceding year; the figure for 2001 is 45%. Similarly, in 1995, 19% of all high school students consumed cannabis more than six times monthly; the figure for 2001 is 25%. This means that, consumption levels in Canada appear to be among the highest in the world for this age group.

To summarize

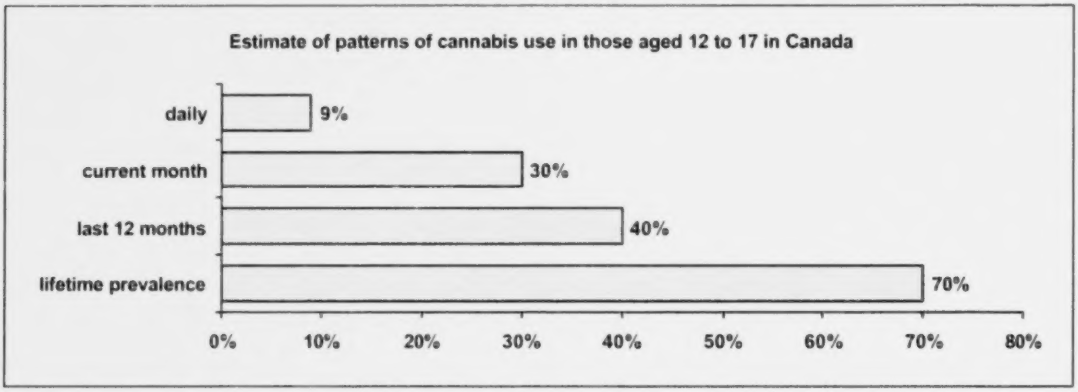
In the absence of recent reliable data on a national scale, we can only hypothesize. For the population over age 16, there is reason to believe that cannabis use is as follows:

[27] Table adapted from Rigter and von Laar, *op. cit.*, page 20.



Based on the last census, there are approximately 20 million Canadians between the ages of 18 and 64. If we accept the values used in this graph, there are then approximately 2 million Canadians over age 18 who have used cannabis during the preceding 12 months, approximately 600,000 who have used it during the past month, and approximately 100,000 who use it daily.

In young people aged 12 to 17, the situation could be as follows:



According to the latest census, there are approximately 2.5 millions young persons aged 12 – 17 in Canada. If 40% have used cannabis in the preceding year and 30% in the past month, this means 1 million and 750,000 young users in each category respectively. Approximately 225,000 would make daily use of cannabis.

Overall, these epidemiological trends indicate a number of things. At the simplest level, they clearly show division by generation and gender: people under the age of 35 consume more than those over 35; and men are more frequent consumers than

women. Furthermore, users are more likely to be single. The data appear constant both over time and among countries.

At the same time, there have been changes to the user profile. Rates for the 30-49 age group have tended to increase, supporting to some extent the hypothesis that these are the first cohorts of '70s users. Although the tendency in the '60s was to identify users as working-class or unemployed, there has been an increase in employed individuals with post-secondary or university education.

Some authors link usage to living in an urban area–for example, in the Netherlands, use is far more widespread in metropolitan than in rural areas. This factor does not apply in Canada. In Ontario for example, students outside Toronto consume more cannabis than do those in Metro Toronto. Cannabis use is also related to non-practice of religion, families in which at least one parent has a post-secondary education, and single parent families.[28]

According to the Ontario studies, age of initial use seems to be lower than it was in the 1970s (close to 16 years of age); it now stands at between 13 and 15 years of age (a mean of approximately 14). On the other hand, as we have said, early initial experience is down (currently 2% compared to 8% in the early 1980s). If age of first experience appears related to regular consumption in late adolescence and early adulthood (18-25 years) as suggested by the American studies, it is clear that consumption is inversely proportional to age and the rate of cessation is high. For those who continue to consume in the long term, the age of cessation is delayed until the late 30s.

On a more complex level, these trends would lend support the OFDT hypothesis concerning "trivialization" of cannabis consumption. The following section shows that a number of researchers–including persons who have testified before the Committee–impute this "trivialization" to a reduction in the perception of cannabis-related risks (health and legal consequences) and greater availability. Aside from "trivialization", there is also an acculturation aspect, the idea that cannabis will eventually be considered a psychoactive substance akin to alcohol or tobacco, whose risks we learn to recognize and manage.

Furthermore, cannabis consumption rates vary widely from one country to another with no apparent relation to public policy. This is one of the strong hypotheses that we will revisit in greater detail in our Chapter 21 examination of public policy.

---

[28] See for example Rigter, H. and M von Laar (2002) "Epidemiological aspects of cannabis use." in Pelc, I. (ed.) *International Scientific Conference on Cannabis*. Brussels.

PATTERNS AND CIRCUMSTANCES OF USE

Why do people use cannabis? In fact, why have people felt the desire or the need to use all manner of psychoactive substances since time immemorial? We suspect that these questions are highly charged with symbolic and political meaning: when it is a question of cannabis, sometimes the focus is on its "soft drug" nature, its festive and sociable side, and sometimes the focus is more on its role as part of a marginal, if not pre-delinquent, trajectory and the risks associated with moving on to other drugs. When it comes right down to it, and rather surprisingly, we know very little about users' motivations and experiences.

We can distinguish two large groups of studies: socio-anthropological studies that try to identify users' practices and certain environmental factors that put these practices in context, and psychological studies that try to relate personality and family-related factors to cannabis use. Although both types of studies are just as relevant to understanding the nature of the phenomenon, their approaches and their results are often difficult to reconcile. But, first, a few historical notes on the uses of cannabis.

Cannabis in history[29]

Although the historical routes of cannabis still remain obscure, archaeologists discovered a Chinese village where they uncovered the oldest use of the cannabis plant, dating back approximately 10,000 years. It was primarily used for clothing, ropes and fishing nets, paper and other decorative purposes. It was also considered one of China's five cereals. Around 2000 B.C. the Chinese became aware of the psychotropic and medicinal properties of cannabis oil (resin) and used it in particular for the treatment of menstrual fatigue, gout, rheumatism, malaria, constipation and absentmindedness, and as an anaesthetic. Religious uses were also identified, and the Chinese noted that its use allowed communication with spirits and lightened the body. In the first century B.C., Taoists used cannabis seeds in their incense burners to induce hallucinations that they considered a way to achieve immortality.

Several historians attribute the origins of cannabis to the Scythians around Siberia and North Central Asia towards the 7th century B.C. According to Herodotus, a Greek historian who lived in the 5th century B.C. marijuana was an integral part of the cult of the dead that the Scythians followed to honour the memory and spirit of their departed leaders. Indications of cannabis use, often for religious purposes, have also been found with the Sumerians and, according to some, in certain passages of the Bible.

---

[29] This section is based extensively on Spicer, L. (2002) *Historical and Cultural Uses of Cannabis and the Canadian "Marijuana Clash"*, Ottawa: Library of Parliament, report commissioned by the Committee from the Library of Parliament.

The first ethnographic description of ancient people inhaling marijuana as a psychotropic stimulant was confirmed by a Russian anthropologist, Rudenko, in 1929. Not only did he find the embalmed body of a man and a bronze cauldron filled with burnt marijuana seeds, but he also found shirts woven from hemp fibre and metal censors designed for inhaling marijuana smoke. Apparently this activity was not religious in nature but was a daily activity in which both men and women participated, as confirmed by the discovery of the frozen body of a 2,000-year-old woman in the same cemetery where Rudenko made his first discovery. Archaeologists found some of her possessions, including a small container of cannabis that would have been smoked for pleasure and used in pagan rituals, buried in a hollow tree trunk.

In India, cannabis has been closely associated with magical, medical, religious and social customs for thousands of years. According to legend found in the Vedas, Siva is described as "The Lord of Bhang", a drink made of cannabis leaves, milk, sugar and spices. This drink is still part of the traditions of certain castes. Cannabis is also renowned for its use in Tantric sexual practices. Approximately one hour before the yoga ritual, the devotee drinks a bowl of bhang after reciting a mantra to the goddess Kali. Similarly, "charas" holds a special place in the prayer ceremony called Puja. Lastly, cannabis was used for medical purposes.

Although not indigenous to Africa, the cannabis plant is part of religious, medical and cultural traditions across almost the entire continent. In Egypt, it has been grown for over a 1,000 years, while the first evidence of its presence in central and southern Africa dates back to 14th century Ethiopia where ceramic smoking-pipes containing traces of cannabis were discovered. In North Africa, cannabis influenced music, literature and even certain aspects of architecture since in some homes, a room was set aside for kif where family members gathered to sing, dance and tell stories. The plant was also used as a remedy for snake bite (Hottentots), to facilitate childbirth (Sotho) and as a remedy for anthrax, malaria, blackwater fever and blood poisoning (former Rhodesia).

In South America, it would have been primarily slaves imported from Africa who brought cannabis. East Indian labourers brought cannabis to the Antilles, and Jamaica in particular, where it is not only used recreationally but is integrated in many aspects of Jamaican, and particularly Rastafarian, culture.

As for North America, it is not known exactly when the psychotropic properties of cannabis were discovered. Some think that it played a role in several native cultures; others doubt that it ever played a significant role. The oldest evidence of the existence of cannabis in North America dates back to Louis Hébert, Champlain's apothecary, who introduced cannabis to white settlers in 1606, essentially as a fibre to be used to make clothing, cordage, sails and rigging for ships. However its psychotropic properties were not discovered until the 19th century. Between 1840 and 1900, it was used in medicinal practice across almost all of North America. It was prescribed for various conditions such as rabies, rheumatism, epilepsy and tetanus, and as a muscle relaxant.

Moreover, its use became so widespread that cannabis preparations were sold freely in drug stores.

The first study of cannabis was conducted in 1860 by the *American Governmental Commission.* When presenting the findings of the Commission to the *Ohio State Medical Society*, Dr. Meens said:

> *Cannabis effects are less intense than opium, and the secretions are not so much suppressed by it. Digestion is not disturbed; the appetite rather increases; the whole effect of hemp being less violent, and producing a more natural sleep, without interfering with the actions of the internal organs, it is certainly often preferable to opium, although it is not equal to that drug in strength and reliability.* [30]

At the same time, other doctors criticized its use because of the variability and uncertainty of its effects. As for its recreational uses, they seem to have been noted for the first time at the beginning of the 20th century and quickly became the subject of social concern, especially because of the association of cannabis with Mexican and then black American workers, strengthening fears about its criminogenic and aphrodisiac effects. In 1915, California became the first state to prohibit possession of cannabis. Canada followed suit in 1923, while the United States outlawed possession in 1937. However, in 1944, the La Guardia report, from the State of New York, emphasized the harmless effects of cannabis. It was followed by reports from the Le Dain Commission in Canada and the Schafer Commission in the United States at the beginning of the 1970s. On the international scene, cannabis was prohibited by the Single Convention of 1961 (which will be discussed more fully in Chapter 19).

In Canada, mass use of cannabis came with the 1960s. Prior to that, the phenomenon was almost invisible and there were only 25 convictions for cannabis possession between 1930 and 1946. In 1962, the RCMP reported 20 cannabis-related cases. Then came the explosion: 2,300 cases in 1968 and 12,000 cannabis convictions in 1972. According to the Le Dain Commission, the sudden growth in cannabis use could be attributed to the hippies, the Vietnam War, underground newspapers and the influence of the mass medias. On top of these major counterculture movements, Canada became more open to the world: more and more young Canadians were travelling and Canada itself received more and more visitors and immigrants. Since then, except for a few years, cannabis use for non-medicinal purposes has increased as we saw in the previous section.

Trajectories of use

Most studies identify quantity and frequency of use. Thus as we saw in the previous section, the OFDT report, for example, identifies experimentation, occasional, repeated, regular and heavy use, with frequency of use (number of times a month) and circumstances (alone or in a group, morning or evening) as the preferred indicators of

---

[30] Quoted in Spicer, *op. cit.*, page 29.

at-risk use. However, this knowledge of certain characteristics of use by young people in particular tells us very little about what will follow. If we could stop time at a given moment in a user's history, the knowledge would not help us determine what would happen next. For example, with this knowledge we could not answer the question of whether or not cannabis use begun during adolescence is part of a trajectory leading to increased use. Now, a certain number of those who testified before the Committee told us that they had observed dependence in cannabis users. Also, certain government documents, in the US in particular, do not hesitate to point in this direction by measuring requests for treatment and by reporting that requests for treatment of cannabis dependence are on the rise. For example, documents given to us by American drug authorities indicate that 40% of people who meet the DSM IV diagnostic criteria for dependence (which will be dealt with in the following chapter) have a primary diagnosis of cannabis dependence.[31] Unless we believe that a few occasional uses lead to dependence, we must accept that a relatively significant number of young people who try cannabis during adolescence will embark on a trajectory of use that will lead to dependence.

But what is the situation exactly? What are these trajectories of use? What are the stages? Is there a progression?

First of all, like Professor Mercier, we must point out that the idea of a trajectory is itself slightly inaccurate.

> *The concept of trajectory is based first of all on the basic principle whereby individuals will go through a number of stages or successive phases. It is true that the concept of trajectory is somewhat incorrect. A trajectory is somewhat of a metaphor for the trajectory of the planets and the stars, that is something very focused and in continuous motion. The word "journey" ("trajet") would be more accurate. A journey includes detours, round trips, et cetera. So we must bear in mind that this concept of trajectory is not necessarily linear, but that there will be different situations and different paths. The word "journey" is a more accurate way of describing the relationship an individual will have with psychotropic substances during his or her life. There is another important concept as well. In addition to trajectories, phases and stages, there are also transitions and passages, when individuals move from one stage to another.*[32]

Some, like the INSERM report, speak of contact, experimentation and commitment phases. Contact is seeing cannabis or knowing people who use it. Experimentation, of course, is trying it, and may be limited to a single time. Lastly, commitment refers to the various ways of managing use, from relative commitment where there are significant changes in use to true commitment where there are fewer changes. The report specifies that these three stages are not in all trajectories and do not always follow one another in a coherent fashion. Furthermore, there will often be

---

[31] Office of National Drug Control Policy (2002) *National Drug Control Strategy*. Washington, DC: The White House.

[32] Professor Céline Mercier, testimony before the Special Senate Committee on Illegal Drugs, Canadian Senate, first session of the thirty-seventh Parliament, December 10, 2001, Issue No. 12, Page 6.

periods of cessation, followed by resumption or a definitive cessation. Nevertheless, according to INSERM, *"commitment probably constitutes the most important stage if we want to understand what cannabis use corresponds to. However, the data on this commitment phase seems the most inconsistent as most works deal with initiation."*[33] [translation]

In fact, the data on committed use is still very sketchy, such that beyond a few generalities, we really know very little about the circumstances and trajectories of cannabis use. It is as if we were first worried about classifying users according to their risk of becoming dependent, or were trying to make them fit into a ready-made model. While testifying before the committee, Professor Mercier recalled the five stages in the classic pattern of addiction: initiation, gradual start of abuse, dependency, treatment and reintegration. However, as she pointed out, this is only one of the possible trajectories, the one that has been studied most frequently with regard to drugs (alcohol, heroin and cocaine in particular), and yet it hardly applies to cannabis. In any event, it is clear that with cannabis users, there is great variability in use.

The epidemiological data presented in the previous section indicate fairly clearly that cannabis use decreases significantly with age. More specifically, the rate of cessation is significant, as the following table shows.

Rate of Cessation (percentage of lifetime users who did not use cannabis in the previous year), USA, 1996 [34]

Age Group	Women	Men
12-17	26%	20%
18-25	54%	39%
26-34	82%	74%
35 +	91%	82%

Consequently, the rate of continuation is relatively low. It was 24% in the US in 2000, 17% in Denmark, 29% in France and Germany (West), 24% in Switzerland and 8% in Sweden. The only exception is Australia with a rate of continuation of 46%.

That being said, these data says nothing about the period during which cannabis use is continued, the frequency of use or the quantities used. Epidemiological studies tend to establish that most users stop consumption during their thirties, but only ethnographic studies can provide more information. Unfortunately they are few.

The INSERM report describes studies conducted in Australia, France and the United States. Most show progress towards regulated cannabis use, that is, use both

[33] INSERM (2001), *op. cit.*, page 28.
[34] Rigter, H. and M. von Laar, *op. cit.*, page 27.

stabilized–fewer variations in use–and use more integrated into social living conditions, that is, more integrated into personal and professional life. A significant proportion of long-term regular users are men, and are more likely to be single and have creative occupations. Most say they use cannabis to relax and relieve stress, to help them sleep, or to alter their state of consciousness.[35]

In Canada, Hathaway studied regular users[36], using open-ended interviews from October 1994 to June 1995. The study involved a sample of 30 regular users (15 men and 15 women), aged 22 to 47 (average age 32). Participants had used cannabis for 3 to 31 years with the average being 17 years; 40% had used it daily for 20 years or more. This data is in complete agreement with what INSERM suggested. Long-term users integrate their regular cannabis use into their daily lives and social activities while remaining aware of the symbolic value of this "tolerable deviance". While most started after coming into contact with a small group of users who served as more or less long-term support, the users who were most at peace with their drug use were those who regulated their use independently.

> *In this study, I found that moving from a pattern of use that is dependent on one's level of participation with other users to one that is independently regulated marks a crucial transition in the marijuana user's relationship to the drug. (...) their continuing use of the drug does not necessarily suggest an inability to commit to conventional adult roles. Instead, adapting one's marijuana use to suit an otherwise conventional way of life appears to make the practice significant on a more personal level than that previously fostered through affiliation with marijuana-using groups.* [37]

For a certain number of users, this acculturation of the drug occurs after a more or less prolonged period of abstinence during which they distance themselves from the group of users. This makes it possible for them to determine for themselves the role cannabis will play in their lives. Moreover, every participant in the study had managed to integrate their use into their personal or professional life. Users associate their drug use primarily with free time and relaxation after a day at work; some even compare its role with that played by alcohol. Although 97% used cannabis at least weekly and 37% used it daily, only 7% (2 people) defined their use as problematic. Most went through periods of abstinence or of decreased use without experiencing difficulties.

Another study, reported by Rigter and von Laar,[38] was conducted in the State of New York on a cohort of users who were followed for a period of twenty years. This study identified four types of users:

---

[35] INSERM (2001), *op. cit.*, pages 55-58.

[36] Hathaway A. D. (1997a) "Marijuana and lifestyle: exploring tolerable deviance." *Deviant Behaviour: An Interdisciplinary Journal*, 18, pages 213-232; and (1997b) "Marijuana and tolerance: revisiting Becker's sources of control." *ibid*, pages 103-124.

[37] Hathaway, A.D. (1997a), *op. cit.*, page 219.

[38] Rigter, H. and M. von Laar, *op. cit.*, pages 28-29.

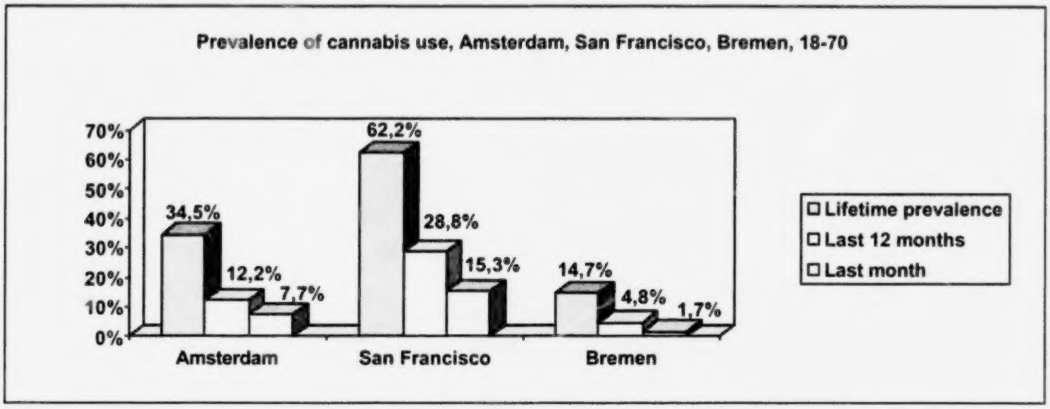
- Early-onset heavy-use: start around age 15 and become regular users around age 17.5; daily use for a duration of 131 months on average; 49% still use around age 34-35;
- Early-onset light-use: start around age 15 but fewer (44%) go on to daily use (for an average duration of 28 months); only 10% still use at age 34-35;
- Mid-onset heavy-use: start around age 16; two-thirds become daily users (average duration 42 months) and still use at age 34-35;
- Late-onset light-use: start at age 19.5 and a minority become daily users (21%). Almost all discontinue use around age 34-35.

In all, this study shows that there were clearly more light users than heavy users. The latter had less education, went to church less often, were more likely to have a history of delinquency, and changed jobs more often. Early-onset users showed a greater tendency towards episodes of delinquency and mental disorders, started to drink and smoke tobacco sooner, had a greater tendency to experiment with other drugs, and tended to identify positive reasons for using marijuana.

But it is risky to propose typologies, because boundaries are fluid and users switch from one type of use to another fairly easily. This was shown in particular by the comparative study conducted by Cohen and Kaal in Amsterdam, San Francisco and Bremen.[39]

The study involved a sample of experienced users consisting of 216 people in Amsterdam, 265 in San Francisco and 55 in Bremen. The sophisticated method of selecting candidates from epidemiological studies conducted in the general population of these cities is important because it reveals the prevalence of use. The following chart shows this data.

[39] Cohen, P.D.A. and H.L. Kaal, *The irrelevance of drug policy. Patterns and careers of experienced cannabis use in the population of Amsterdam, San Francisco and Bremen.* Amsterdam: University of Amsterdam, CEDRO.



The average age of participants varied between 33 and 37; most had a spouse and a stable job. The average age for initiation into cannabis use in the three cities was 16, that is, at a younger age than people who had only occasional exposure to cannabis (21.2 in Amsterdam and 19.5 in Bremen). Most were introduced by friends and their first experience was as part of a group. At age 19, they were regular users (at least once a month) and their heaviest use was around age 21.5. Trajectories of use were determined using six patterns:

1) More to less: after an initial period of heavy use, the individual gradually decreased his use
2) Gradually more: the individual gradually increased his use
3) Stable: amount and frequency did not change
4) Up-top-down: use increased, reached a peak, and then decreased
5) Intermittent: frequent discontinuation after initiation
6) Varying: use rises and falls

As the following table shows, no less than 75% of respondents in the three cities correspond to patterns 4 (48.7%) and 6 (25%).

Patterns of Use in Regular Users [40]

	Amsterdam		San Francisco		Bremen	
	Number	%	Number	%	Number	%
Pattern 1	17	8	18	7		
Pattern 2	13	6	17	6	6	11
Pattern 3	24	11	5	2	5	9
Pattern 4	104	48	133	50	24	44
Pattern 5	7	3	25	9	2	4
Pattern 6	51	24	66	25	18	33

During their period of heaviest use, approximately 45% of those studied used cannabis regularly. However, during the preceding year, approximately 35% used it less than once a week and more than 35% did not use it all. During the past three months, more than 50% did not use cannabis at all, and less than 10% used it on a daily basis. As for amounts, the authors of the study concluded that they are low. During their period of heavy use, less than 18% of those studied smoked more than one ounce per month, whereas during the preceding year, approximately 60% had smoked less than 4 grams (1/7 of an ounce) per month. Users were divided fairly equally between those who preferred medium or mild cannabis and those who preferred a stronger variety (with a more marked preference for the mild varieties in Amsterdam). Users have a certain number of rules regarding use: no smoking at work or school (more than 35%), during the day, or in the morning.

Most long-term users had had periods of abstinence that varied from one month to a year or longer, most often because they no longer felt the need or the desire to smoke. Moreover, between one-third and one-half had decided to decrease their use at various times.

Thus we can see that trajectories of use do not follow a linear progression, and are marked by key periods when the user integrates cannabis use into his social and personal life, distances himself from groups of users, stabilizes the role marijuana plays in his personal life, with periods of heavy use, especially at the beginning of the trajectory, followed by periods of either decreased use or of ups and downs in terms of frequency and amount.

Factors related to use

Following logically from what we saw in the previous section, studies on factors that could explain the use of drugs, and cannabis in particular, deal primarily with initiation or experimentation.

The INSERM report examines a set of studies on factors that could explain cannabis use: the influence of the family environment (use by parents, socialization,

[40] *Ibid.*, page 48.

parental teaching methods, quality of the parent-child relationship, parental models), peers (symbolic values of use, norms) and educational and social environments.[41] There is no clear conclusion, but the report notes that the studies manage either poorly or not at all to take into account the user's role in social situations and consequently the incremental impact on use arising from the variability of social stresses as well as the methods of integration. We would also add that these studies do not reflect trajectories of use.

First of all, along with *DrugScope*, we note that the epidemiological approach to analysis of drug use, cannabis in particular, is based on a medical model of analysis of the prevalence of disease, whereas the reasons (which are not necessarily the causes) for drug use can very easily lie outside the medical field and, in a broader sense, outside the psychosocial model. Attributing dependence – understood here in terms of a disease – to factors pertaining to the relationship between the locus of control and the environment has consequences for the understanding of the phenomenon as well as for public policy. The report by this British body contains a table of the explanations of drug use we feel it useful to reprint here.

Attribution Explanations of Drug Use [42]

Attribution	Common Sense Meaning	Resulting Public Policy
Internal x stable	Drug use is a disease (dependence model)	Treatment model
Internal x unstable	Drug use is the periodic seeking of pleasure	Reduced demand model (replace drugs with something else)
External x stable	Shortcomings in the environment explain drug use	Change the environment
External x unstable	Availability of drugs explains their use	Reduced supply model

In fact, we must not forget that, with regard to psychoactive substances, the medical model of disease is still a dominant model for comprehension and forms the other part of the public response along with the penal model.[43] As we were told several times, drugs, and cannabis in particular, are not dangerous because they are illegal, they are illegal because they are dangerous. We will have occasion to comment on this statement in greater detail in the following chapters.

[41] INSERM (2001) *op. cit.*, pages 28-50.

[42] DrugScope (2001) *United Kingdom. Drug Situation 2000.* Report to the EMCDDA, page: 19.

[43] On this subject, see for example the work of Bergeron, H. (1996) *Soigner la toxicomanie. Les dispositifs de soin entre idéologie et action.* Paris: L'Harmattan; and Barré, M.D., M.L. Pottier et S. Delaître (2001) *Toxicomaie, police, justice: trajectoires pénales.* Paris: OFDT.

For now it is enough to remember that attempts to explain drug use most often involve looking for defects in personality or the environment rather than trying to understand the choices made by users.

Among the factors related to the locus of control, studies identify primarily:

- Peer influences: the first uses depend on the influence of other young people in the group;
- Family influences: a family environment where parental supervision is lacking, where drug use is tolerated, where siblings or parents have criminal backgrounds, and where parents themselves are users;

Among the factors related to the environment, studies mention:

- The availability and accessibility of drugs: the more drugs are available, the greater their use will be;
- Social tolerance: the more drug use is accepted, the higher levels of use will be;
- Perception of risk: the less the risk of social disapproval or the perceived risk to health, or the risk of legal action, the greater the use there will be.

According to the report *Monitoring the Future*, there is no doubt that young people's perceptions of drugs and their attitudes towards them determine the levels of use, which in return must determine public policy:

> *Early in the decade of the 1990s we noted an increase in the use of a number of illicit drugs among secondary students and some important changes among the students in terms of certain key attitudes and beliefs related to drug use. (…) Specifically, the proportions seeing great risk in using drugs began to decline, as did the proportions saying they disapproved of use. As we predicted, those reversals indeed presaged "an end to the improvements in the drug situation that the nation may be taking for granted." The use of illicit drugs rose sharply in all three grade levels after 1992, as negative attitudes and beliefs about drugs continued to erode. This pattern continued for some years.*[44]

And further on:

> *We can summarize the findings on trends as follows: over more than a decade – from late 1970s to the early 1990s – there were very appreciable declines in use of several illicit drugs among twelfth-grade students, and even larger declines in their use among college students and young adults. These substantial improvements – which seem largely explainable in terms of changes in attitudes about drug use, beliefs about the risks of drug use, and peer norms against drug use – have some extremely important policy implications. One is that these various substance-using behaviours among American young people are malleable – they* can *be changed. It has been done before. The second is that demand-side factors appear to have been pivotal in bringing about those changes. The reported levels of availability of marijuana, as reported by high school seniors, has held fairly steady throughout the life of the study. (Moreover, both*

[44] Johnston, L.D., et al., (2001) *op. cit.*, page: 6.

> *abstainers and quitters rank availability and price very low on their list of reasons for not using.). And in fact the perceived availability of cocaine actually was rising during the beginning of the sharp decline in cocaine and crack use, which occurred when the risks associated with that drug suddenly rose sharply. (...) Over the years, this study has demonstrated that changes in perceived risk and disapproval have been important causes of change in the use of several drugs. These beliefs and attitudes surely are influenced by the amount and nature of public attention paid to the drug issue in the historical period during which young people are growing up. A substantial decline in attention to this issue in the early 1990s very likely helps to explain why the increases in perceived risk and disapproval among students ceased and began to backslide.* [45]

In other words, social disapproval – through government information campaigns, for example – can generate attitudes that reject drug use and will be reinforced by actions likely to increase the risks associated with use (the risk of arrest, for example).

A study conducted in Newfoundland and Labrador involving a sample of 3,293 people is an example of this approach applied in Canada.[46] The questionnaire included questions about activities (family activities, housework, extracurricular activities, school work, sports, work, religious life), the availability of cannabis, use by parents, peers and the individual, parental and peer norms regarding cannabis, personal preferences and norms regarding cannabis. Analysis of variance dealt with the interaction of these various variables to explain personal use of cannabis. Overall, the model explains only 57% of use in the provincial sample, 65% for boys and 54% for girls. The results show that peer use is the main factor related to personal use (29% of variance), followed by personal preferences (themselves influenced by peer norms), personal norms and having to do chores around the home. Availability is not directly related to use and works through peer norms and use. Parental use is strongly linked to perceived availability. The authors conclude that this model has clear implications for interventions to prevent cannabis use:

> *In the province wide sample, Peer Use, Peer Norms, Availability, Own Preferences and Own Norms together account for 56% of the 57% of Own Use predicted by the model. Peer Norms and Availability work though Peer Use, so important targets for intervention should be Own Norms, Own Preferences and Peer Use. Of these variables, Own Preferences and Peer Use contribute the most to prediction of Own Use, together accounting for 48.8% of the variance. It is of interest that a large part of availability is predicted by Parental Use, suggesting Peer Use arises from possible supplies of the marijuana/hashish from parental sources. This ought to be a target for intervention strategies as well. The model suggests sources of influence on target variables that ought to be considered in any intervention strategies.* [47]

Taking into consideration the limits of the model as well as the differentiation between the sexes and provincial health districts with respect to the relative weight of

---

[45] *Ibid.*, page 30.

[46] Wasmeier, M., et al., (2000) *Path analysis survey of substance use among Newfoundland and Labrador Adolescents. Marijuana/haschish and Solvent use.* Memorial University of Newfoundland.

[47] *Ibid.*, page 15.

the independent variables, we have to wonder if this type of analysis is a true reflection of use, including initial use. Furthermore, in the light of international trends in use on the one hand, and studies on users on the other, we wonder about the postulates of this type of mechanical model based on the rationality of the actors.

Finally, Aquatias et al., conducted a study on cannabis use among youth in the suburbs of Paris.[48] The authors make a particularly interesting distinction between forms of use based on user characteristics and the ideological representations of cannabis use. They demonstrate in particular (1) that there exist "hard" uses of soft drugs and (2) that the traditional distinction between the festive, socially integrated and group-regulated forms of use among middle class youth, and the excessive and socially unregulated uses of disadvantaged youth does not hold. Depending on factors related to their environment, both groups can have regulated and unregulated forms of use.

Factors traditionally associated with unregulated use such as social disenfranchisement, poor living conditions in the suburbs and the lack of professional integration, are only part of the picture. Other factors related to tensions arising in the environment (for example family-related problems or being in conflict with the law) and the capacity to remain autonomous from their social milieu also play an important role in the trajectories of these cannabis users.

> [Translation] *In trying to understand what factors determined these different forms of cannabis use among these youths, we have obviously noted the importance of factors related to social dislocation: difficulties in social integration and a lack of financial resources capable of fostering their autonomy from the living environment.*
> *However, facing similar difficulties to get a job and socio-economic resources, some smoke cannabis without any excess, some not at all and others smoke considerably. Even within the group of youth who have a job, some smoke high potency cannabis intensively while others have more regulated forms of use and consume less.*
> *Social dislocation is obviously a factor explaining the different forms of use just as integration in the job market serves to regulate these practices. But these complementary factors only constitute the more general context to these behaviours of intensive and prolonged use of cannabis.*
> *(...)*
> *Among those who experience social dislocation the most, those who smoke cannabis in an intensive and prolonged manner also experience the strongest social tensions such as problems with their local reputation, being in conflict with the law or family related problems... (...).*
> *Conversely, those who have a more regulated use are both better integrated in their environment and at the same time more autonomous with respect to local social life.*[49]

[48] Aquatias, S., (1999) « Usages du cannabis et situations sociales. Réflexion sur les conditions sociales des différentes consommations possibles de cannabis. » in Faugeron, C. (éd.) *Les drogues en France.* Paris: Georg. Pour l'étude originale: Aquatias. S. et coll. (1997) *L'usage dur des drogues douces, recherche sur la consommation de cannabis dans la banlieue parisienne.* Paris: OFDT.

[49] Aquatias, S. (1999) *op. cit.*, pages 48-49.

The authors propose a classification of forms of use which we reproduce since it has, in part, inspired our own classification.[50].

	Regulated solitary uses	Regulated group uses	Unregulated solitary uses	Unregulated group uses
Intensive use	After work	Boredom	Personal problems	Holidays, parties
Medium or low level of use	Before and after work	Generally in the evening Boredom		

Finally, the authors distinguish between four levels of use:

- Occasional: from experimentation to use in parties;
- Moderate daily use: 3 to 5 joints per day or about one gram;
- Strong daily use: 5 or 6 joints per day or between 0.9 and 1.2 grams;
- Intensive daily use: over 1.2 gram per day.

To summarize

From an analysis of the life stories of users and their "trajectories", we have learned primarily that, for a proportion of experimenters, which varies between 15% and 20% of the population, who will become regular users, the circumstances and patterns of their "career" as a user vary considerably but that for a significant proportion of these long-term users, use is integrated into their social and personal life.

Further, contrary to some studies, uses of cannabis are not determined only by a series of psychological or environmental factors. In all cases, it seems that specific events, elements of one's particular life story, can trigger unregulated forms of uses, characterized in particular by intensive and solitary use. While such unregulated uses appear to be temporary, we did not come across any study that examined the trajectories of these users.

We also note that negative social attitudes and the characteristic of the cannabis market appear to have little impact on patterns of use.

Finally, we note that regular use does not necessarily mean problem use. At the same time, we have learned that early onset and rapid progression towards regular use are factors in problem use. In other words, and this will be important for choosing public policy and interventions, initiation at a young age (under age 16) and rapid progression towards regular use (under age 20) are markers that should be used to identify and prevent heavy use. Chapter 7 will discuss this issue in greater detail.

[50] *Ibid.*, page 45.

STEPPING STONE TO OTHER DRUGS?

The stepping stone theory holds considerable sway in debates on marijuana. In fact, the concern is that cannabis use leads to the use of other drugs, in particular, the so-called hard drugs, such as heroin and cocaine.

> *It logically follows that more people using drugs will increase the number of people being harmed by them. Cannabis is believed to be the foundation upon which most young people begin experimenting with illicit drugs. (...) The "gateway" concept has been around for a long time, and again, although there is no definitive evidence, the National Institute on Drug Abuse has reported that neuro-toxicological research suggests that marijuana "may alter the brain in ways that increase the susceptibility to other drugs." Many believe that cannabis use provides the impetus for those people looking to increase the psychotropic effect a drug has on them.* [51]

We should first define our terms. The "stepping stone" theory holds that cannabis use inevitably leads to use of other drugs. In this theory, cannabis use would lead to neurophysiological changes, affecting in particular the dopaminergic system (also called the reward system), thus creating the need to move on to the use of other drugs. This theory has been completely dismissed by research. We share this conclusion with several international bodies doing drug research, including the British organization *DrugScope*:

> *The Stepping-Stone theory has proved unsustainable and lacking any real evidence base. The "evidence" that most heroin users started with cannabis is hardly surprising and demonstrably fails to account for the overwhelmingly vast majority of cannabis users who do not progress to drugs like crack and heroin. The Stepping-Stone theory (often confused among the general public for the Gateway theory) has been dismissed by scientific inquiry. The notion that cannabis use "causes" further harmful drug use has been, and should be, comprehensively rejected.* [52]

The "gateway" theory suggests that users' trajectories offer them choices as they start their trajectory of use and that one of these choices is to use other drugs. According to this theory, certain factors, such as early initiation and more regular and heavier use, reinforce this possibility. However, these factors themselves, and early initiation to cannabis in particular, are related to earlier factors, arising from the family environment and social living conditions, that predispose the more vulnerable young people to this early initiation and more rapid progress towards regular and heavy use.

---

[51] M. J. Boyd, Chair of the Drug Abuse Committee and Deputy Chief of the Toronto Police Service, Canadian Association of Chiefs of Police, testimony before the Special Senate Committee on Illegal Drugs, Canadian Senate, first session of the thirty-seventh Parliament, Issue 14, page 75.
[52] DrugScope (2001) *Evidence to Home Affairs Committee Inquiry into Drug Policy*. Available on-line at: http://www.drugscope.org.uk/druginfo/evidence-select/evidence.htm

> *The link between cannabis and other drug use, according to this explanation, is thus a reflection that there are a number of risk factors and life pathways that predispose young people to use cannabis and that they overlap with the life pathways that predispose young people to use other illicit drugs.* [53]

In addition to these factors that predispose some young people to heavier use of psychoactive substances – including alcohol and tobacco first of all – the sociological conditions under which users can obtain cannabis are such that they are in contact with an environment that is at least marginal if not criminal. Dealers are often the same people who also sell heroin, crack, amphetamines, cocaine and ecstasy such that the probability that a young cannabis user, already more vulnerable due to the factors of his personal trajectory, would come into contact with these other substances more easily. We would also add that wholesalers and dealers "cut" or even mix their products; we were told at times that ecstasy, for example, could contain many things other than MDNA.

Furthermore, if it is true that use of substances such as heroin and cocaine develops almost necessarily out of prior use of marijuana, then it also develops out of the use of other substances, nicotine and alcohol in particular, which are more gateways to a trajectory of use than cannabis.

If we come back to trends in drug use in the population, while more than 30% have used cannabis, less than 4% have used cocaine and less than 1% heroin.

However, it is true that regular and heavy users are more likely than occasional users to use other substances. The study by Cohen and Kaal[54] discussed in the previous section shows for example that more than 90% of long-term cannabis users have also used tobacco and alcohol during their lifetime. Above all, it also shows that 48% in Amsterdam and 73% in San Francisco have used cocaine at least once in their life, and 37% in Amsterdam, 77% in San Francisco and 47% in Bremen have used hallucinogens at least once. Nevertheless, no regular cannabis users were regular users of other substances. The authors also show that the most common sequence is alcohol (around age 14), tobacco (around age 15), cannabis (around age 17), followed by other drugs in the early 20s.

We feel that the available data show that **it is not cannabis itself that leads to other drug use** but the combination of the following factors:

- Factors related to personal and family history that predispose to early entry on a trajectory of use of psychoactive substances starting with alcohol;
- Early introduction to cannabis, earlier than the average for experimenters, and more rapid progress towards a trajectory of regular use;
- Frequenting of a marginal or deviant environment;
- Availability of various substances from the same dealers.

---

53 *Ibid.*

54 Cohen and Kaal, *op. cit.*, page 92-93.

CANNABIS, VIOLENCE AND CRIME

It is clear that there is some association between psychoactive substances and crime. It is just as clear that this link is much more complex than is sometimes thought, as Professor Brochu pointed out during his testimony before the Committee.

> *Just in my office at the Université de Montréal, I have 2,973 studies that attempt to show a link between psycho-active substances and crime. Most of these studies come from the United States or from English-speaking countries, which tends to colour their perspective somewhat, since we know that our neighbours to the south have very clearly opted for a punitive approach to illegal drugs. What comes out of all these studies is that the link between drugs and crime is very complex.* [55]

Since his testimony, Professor Brochu has released the study he mentioned to the Committee.[56]

We can examine the drug-crime relationship from at least three angles: the effects of the substance itself, the effects of the cost of the substance, and the drug's position in the criminal world.

A significant proportion of offenders have psychoactive substance abuse problems, predominantly with alcohol. In fact, the study concludes that alcohol is the substance most frequently associated with violent crime; in the case of crimes against property, illegal drugs predominate. Cannabis ranked third (3% to 6% according to the study), far behind alcohol (24%) and cocaine (8% to 11%).

With respect to the second approach, the authors establish that between 17% and 24% of inmates committed a crime to obtain the money needed to buy their substance of choice, most often cocaine.

Lastly, regarding the third approach, because illegal drugs are marginalized, users are exposed to a deviant environment. In the previous section we noted that, with regard to cannabis, the fact that dealers can offer heroin or crack as well as cannabis could promote a gateway trajectory towards these other drugs. Similarly, the fact that these substances are illegal could contribute to leading people to a trajectory of delinquency. Furthermore, the drug trafficking environment is a relatively violent environment where a whole series of crimes are committed. Lastly, the simple fact of selling cannabis is itself a criminal offence, and we know that a certain number of people are imprisoned for doing so.

All in all, cannabis itself does not lead to a trajectory of delinquency and it is more likely to be the other way around: someone who embarks on a trajectory of delinquency

---

[55] Professor Serge Brochu, Université de Montréal, testimony before the Special Senate Committee on Illegal Drugs, Canadian Senate, First Session of the Thirty-Seventh Parliament, December 10, 2001, Issue 12, page 18.

[56] Pernanen, K. et al., (2002) *Proportions of crimes associated with alcohol and other drugs in Canada.* Ottawa: Canadian Centre on Substance Abuse.

when young is exposed to illegal drugs more quickly and can experiment at a younger age and begin a career as a user when younger.

Furthermore, simply because of its relaxing and euphoristic psychoactive effects and its effect of relaxing muscle tone, cannabis is hardly likely to lead to acts of violence.

Data from studies on long-term users confirm this global picture of the relationship between cannabis and crime. Thus, Cohen and Kaal noted that less than 5% of their respondents had committed offences to obtain cannabis (pilfering, shoplifting, theft). The offence committed most frequently in order to obtain cannabis was selling it.

In short, the Committee has learned that cannabis is not a cause of violence or crime except in rare cases, and of course excluding driving while under the influence, which will be dealt with in Chapter 8.

CONCLUSIONS

We have learned the following from all the information on trends, patterns, circumstances, trajectories and social consequences of cannabis use:

	Conclusions of Chapter 6
On trends in use	➢ **The infrastructure of national knowledge about the trends and circumstances of cannabis use is fundamentally weak and desperately needs strengthening.** ➢ **The epidemiological data available indicates that close to 30% of the population (12 to 64 years old) has used cannabis at least once.** ➢ **Approximately 10% used cannabis during the previous year.** ➢ **Up to 30% of those who used cannabis in the last year are current users (have used cannabis this month).** ➢ **Approximately 15% of current users would be daily users** ➢ **Use is highest between the ages of 16 and 24.** ➢ **The prevalence of use during the current year is highest, approximately 40%, in young people of high school age.** ➢ **The prevalence of monthly use in young people is approximately 30%.** ➢ **The prevalence of daily use in young people is approximately 9%.**
On trajectories	➢ **The average age of introduction to cannabis is 15.** ➢ **Most experimenters stop using cannabis.** ➢ **Regular users were generally introduced to cannabis at a younger age.** ➢ **Long-term users most often have a trajectory in which use**

	rises and falls. ➢ Long-term regular users experience a period of heavy use in their early 20s. ➢ Most long-term users integrate their use into their family, social and occupational activities.
On the gateway effect	➢ Cannabis itself is not a cause of other drug use. ➢ Cannabis use can be a gateway because it is illegal, which puts users in contact with other substances.
On violence and crime	➢ Cannabis itself is not a cause of delinquency and crime. ➢ Young people with a trajectory of regular and heavy use are often already on a deviant if not delinquent trajectory. ➢ Cannabis is not a cause of violence.

CHAPTER 7

CANNABIS: EFFECTS AND CONSEQUENCES

Cannabis, as we saw in Chapter 5, acts on the central and peripheral nervous systems in various ways. While research has established a fairly clear role for some of the components of cannabis, Δ^9THC in particular, the main active component, we are less sure of the role of other chemicals. Similarly research, which is often conducted on laboratory animals or in an even more specialized manner on molecules extracted for experimental purposes, does not reflect the conditions under which the average user uses marijuana. We have seen that, in some cases, dosages used for experimental purposes on laboratory animals, in particular to determine the chronic effects of regular use, are dosages that are unimaginable for humans, the equivalent of 570 marijuana cigarettes a day. Since THC content varies greatly with the cannabis available on the market, since users make different use of the drug depending on the place and circumstance, and since individual characteristics interact with the actual effects of cannabis, knowledge of the effects is necessarily influenced.

From an even more technical standpoint, we should point out that a statistical association – that is, the fact that two facts are concomitant – in no way indicates causality. To infer causality, a certain number of methodological prerequisites must be satisfied. In addition to the statistical association, we must be able to dismiss chance and alternative hypotheses, and show that the causative factor does precede the inferred consequence. According to the WHO:

> *Causal inferences can be drawn from research findings by judging the extent to which the evidence meets widely accepted criteria. These include: strength of association, consistency of association, specificity, dose-response, biological plausibility, and coherence with other knowledge. These criteria are not sufficient to show that an association is causal but the more are met, the more likely it is that the association* **is** *causal.* [1]

[1] World Health Organization (1997), op. cit., page: 3; on this question also see: Hall, W. (1987) "A simplified logic of causal inference" *Australian and New Zealand Journal of Psychiatry*, 21: 507-513.

Moreover, a strong tradition in the philosophy of science holds that you can never prove a hypothesis. The most you can do is falsify – that is, dismiss – alternative hypotheses.[2]

To try to meet the requirements of causality, researchers have developed sophisticated research methods, providing in particular for the random selection of subjects for a study, the random assignment to experimental conditions and non-experimental conditions (control group), the use of double blind and placebo techniques, the careful control of intervening variables that could represent as many alternative hypotheses as researchers are trying to eliminate. This is how, for example, they usually try to test medications that are put on the market.

For most questions involving human behaviour, *a fortiori* in society, it is difficult and rarely possible to establish such a causality relationship for the simple reason that each of these methodological requirements can rarely be met. In our case, the effects of cannabis use, the methodological constraints are particularly obvious. We cannot gather a random sample of cannabis users since we don't know the population. Therefore we must rely on alternative methods for selecting subjects (volunteers, for example). It is difficult to have people smoke cannabis who would otherwise never use it[38] without running the risk of contravening certain rules of ethics, or even legal provisions. And if we resort to people who have already smoked it, there is necessarily contamination of the control group. The cannabis that is used in the lab may be completely different from that of users who buy it off the street. And controlled laboratory conditions definitely do not reproduce the methods of cannabis use, which we know are usually a form of social ritual. As for studies–and they are numerous–conducted on animals (monkeys, mice, rats…), they may be interesting, but the possibility of transposing their results onto humans is limited. Lastly, we note that, as most cannabis smokers also smoke tobacco and drink alcohol, it is difficult to separate the effects of one from the effects of the others.

Obviously that does not prevent researchers from conducting studies, and these studies are also necessary. However, it does require researchers to be as prudent as possible when interpreting their results, in particular with respect to the ability to generalize about all marijuana users and to draw causal inferences. This is a caution that we do not always find, far from it, as this chapter will repeatedly show.

Lastly, we should note the distinction between effects and consequences. Smoking cannabis has immediate effects, some physiological and some psychosocial, that we must describe. But smoking cannabis, especially repeatedly, can also have consequences, some immediate – for example, the ability to perform certain tasks or

---

[2] On this subject, see the works of Karl Popper in particular (1978 for the French edition) *The Logic of Scientific Discovery* Paris: Payot, and (1985) *La connaissance objective.* Bruxelles: Complexe.

[3] It is even a little ironic that the National Institute on Drug Abuse (NIDA) in the US finances studies that have people smoke when the Institute believes that cannabis is a gateway drug: for example, see the study by Haney, M. et al. (1999) "Abstinence symptoms following smoked marijuana in humans" *Psychopharmacology*, 141; 395-404.

the ability to drive a vehicle – and others more distant – for example if smoking cannabis results in a greater risk of lung cancer and if it has a lasting effect on memory.

We are aware of just how arbitrary these distinctions can be insofar as a human being is a whole, an organism integrated into his emotional and social environment and into his ecosystem. The physiological, psychological and social effects interact with one another, infiltrate one another, influence one another and act together rather than separately. In some ways, these distinctions remain the reflection of our incompetence, or at least of our inability, to think about the various systems of a human being as a whole, from every angle. This same incompetence can, also in part, explain the difficulty we have in creating a drug policy. It is to be hoped that those who come after us will be able to develop an integrated, holistic approach. For now, we are forced to use the means at our disposal, our fragmented understanding.

One last preliminary note. We were constantly guided by the need to be rigorous. Be that as it may, our resources did not enable us to be completely thorough and to examine the studies one by one for all these questions. In total, we know that approximately ten thousand studies have been published on cannabis over the last forty years! However, as Nelson points out, "*Although the total volume of this literature is somewhat daunting at first glance, a sampling of the material soon reveals that much is repetitive and a relatively small number of papers are continually referred to by most authors.*"[4] Despite this repetition, we could not go without examining a certain number of these studies. That is why we commissioned the preparation of a summary report[5] and also examined the summaries of scientific literature that were prepared in recent years.[6]

This chapter is divided into five sections. The first is a collection of statements on the presumed effects of marijuana that the Committee heard or that it was made aware of through its research. The following three sections examine the acute effects of cannabis, followed in turn by the physiological and neurological consequences, the psychological consequences and the social consequences. Then, because of its significance and the central place it holds in social and political concerns, we turn our attention specifically to the question of dependence possibly arising from prolonged use of cannabis.

---

[4] Nelson, P.L. (1993) "A critical review of the research literature concerning some biological and psychological effects of cannabis" in Advisory Committee on Illicit Drugs (eds.) *Cannabis and the law in Queensland: A discussion paper.* Brisbane: Criminal Justice Commission of Queensland.

[5] Wheelock, B. (2002) *op. cit.*

[6] In particular the previously mentioned INSERM report (2001), *op. cit.* and the report from the International Scientific Conference on Cannabis (2002); as well as the report from the National Institute of Medicine in the US and the book edited by Professor Kalant, one of our witnesses.

EFFECTS AND CONSEQUENCES OF CANNABIS: WHAT WE WERE TOLD

During the hearings, many witnesses told us what they knew about the effects of cannabis. Some of this knowledge came from their own research work. Other knowledge came from their professional experiences. And lastly, other knowledge was either their interpretation of scientific literature or anecdotes. In this section, we will not make distinctions between the testimony and we will not evaluate its validity. We only want to highlight the richness, as well as the complexity, of what we were told.

> *Message number one is that drugs, including cannabis, are harmful. (...) There is considerable misinformation about the physiological consequences of cannabis use. There is no doubt that heavy use has negative health consequences. The most important are in the following areas: respiratory damage, physical coordination, pregnancy and postnatal development, memory and cognition, and psychiatric effects. (...)*[7]

> *Generally, marijuana (cannabis) and its derivative products are described in this context to distance the drug from the recognized harm associated with other illegal drugs. This has been a successful yet dangerous approach and contributes to the misinformation, misunderstanding and increasing tolerance associated with marijuana use. Marijuana is a powerful drug with a variety of effects. Marijuana users are subject to a variety of adverse health consequences that include respiratory damage, impaired physical coordination, problem pregnancy and postnatal deficits, impaired memory and cognition, and psychiatric effects. Marijuana use is associated with poor work and school performance and learning problems for younger users. Marijuana is internationally recognized as a gateway drug for other drug use. Risk factors for marijuana dependence are similar to those of other forms of drug abuse. (...) It was the consensus of the international community to put marijuana and other substances under international control. That decision was based on evidence of its harmfulness to human health and its dependence potential.*[8]

> *I wish to briefly review two of what I believe are fairly well-established, harmful effects of marijuana, and a number of other areas where there is considerable contention. (...) By far the most consistent and clear-cut effect of marijuana is disruption of short-term memory. Short-term memory is usually described as "working" memory. It refers to the system in the brain that is responsible for short-term maintenance of information needed for the performance of complex tasks that demand planning, comprehension and reasoning. The relatively severe impairment of working memory may help to explain why, during the*

---

[7] Testimony of Michael J. Boyd, Chair of the Drug Abuse Committee and Deputy Chief of the Toronto Police Service, for the Canadian Association of Chiefs of Police, Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, Issue No. 14, page: 74.

[8] Testimony of Dale Orban, Detective Sergeant, Regina Police Service, for the Canadian Police Association, Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, Monday, May 28, 2001, Issue 3, page: 47. It should be immediately noted that the last statement is completely false as we will see in Chapters 19 and 12 on international agreements and Canadian legislation that have placed cannabis on the list of controlled drugs since 1924, with no knowledge of its physical or psychological effects at that time, and for completely different reasons, when there were any.

marijuana high, subjects have difficulty maintaining a coherent train of thought or conversation. (...) Obviously this is relevant if you are going to school stoned. (...) It is becoming increasingly clear that cannabis is a drug on which regular users become dependent, and that this adversely affects large numbers of people.[9]

Marijuana has been shown to be associated with reckless drivers and motor vehicle accidents. Evidence suggests that marijuana may contribute to an appreciable number of traffic deaths and injuries in Canada. It has been shown to negatively affect the academic and social development of some adolescents. Marijuana can cause emotional and medical problems. Chronic use may be associated with lung diseases such as bronchitis, emphysema and cancer. A psychosis may develop in some individuals while other psychiatric symptoms such as anxiety, low mood, depression and panic do occur. Marijuana is known to be addictive. Although the rate of addiction varies, it is between 5 per cent and 10 per cent. I should like to stress that addiction is a disease and marijuana has the potential to be addictive to a genetically predisposed group of individuals.[10]

The evidence was that 95 per cent of the marijuana users in Canada are low, occasional, moderate users. Their consumption of marijuana does not impact on their health as long as they are healthy adults. The other 5 per cent are chronic users, people who smoke one or more marijuana cigarettes per day. If they continue to do that, they will ultimately get chronic bronchitis from the smoking process. The same would be true if they were to roll up the grass off their lawns and smoke that. They would inhale heated material over their large airways and cause damage to them. There were three primary vulnerable groups: pregnant women, which we submit is something between the woman and her doctor; the mentally ill, particularly paranoid schizophrenics (...) then, most importantly, immature youth. Young people who become involved with marijuana - particularly on a regular basis - seem to suffer from a disruption of their studies and the maturation process. As is the case with most intoxicants, it is recommended that they not become involved with them until they have matured.[11]

I have one resource from the Center for Substance Abuse Prevention in the U.S., where recent marijuana research and a number of studies indicate some of the risks. We already know and accept that cannabis has negative effects on many systems - respiratory, motor skills, memory and immune - and that it creates drug dependency and tension. In addition, we now know from numerous research studies that there is a definite and acute withdrawal syndrome associated with chronic cannabis use. (...) There is research that suggests there are effects on the developing fetus. (...) I will speak to visual scanning, specifically, attention dysfunction in the form of impaired visual scanning and related functioning. Visual scanning develops particularly in early adolescence, so earlier onset is associated with some concerns there.[12]

[9] Dr. Mark Zoccolillo, Professor of Psychiatry and Assistant Professor of Pediatrics, McGill University and the Montreal Children's Hospital, Special Senate Committee on Illicit Drugs, Second Session of the Thirty-Sixth Parliament, October 16, 2000, Issue No. 1, page 77.

[10] Dr. Bill Campbell, President, Canadian Society of Addiction Medicine, Special Senate Committee on Illicit Drugs, First Session, Thirty-Seventh Parliament, March 11, 2002, Issue No. 14, page: 56.

[11] Mr. John Conroy, Barrister, Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, March 11, 2002, Issue No. 14, page 11.

[12] Dr Colin Mangham, Director, Prevention Source BC., Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, September 17, 2001, Issue No. 6, page: 71.

There are a number of negative health effects that have been created in the lab or have been observed with long-term users (...). There are, of course, health risks and negative health consequences with using the substance, but the majority of those risks only occur under specific circumstances. The majority of the risks are associated with long-term persistent and frequent use, and therefore must be understood as such. There is at this point agreement that the so-called dependence or withdrawal symptom may arise with heavy chronic users, but it is very much limited to that small population. (...) a seminal report by Hall and colleagues from Australia (...) concluded that the major risks of cannabis use can be significantly reduced by avoiding driving under the influence, by avoiding chronic and daily use, and by avoiding deep inhalation. These were the key factors that allowed us to avoid many of the major harms and risks associated with it. [13]

In any event, we are talking about plant derivatives that contain a number of psychoactive alkaloids. The psychoactive effects are predominantly of mild euphoria and time distortion, though disorientation and panic attacks may occur. The appreciation of music, art and food are said to be enhanced, as is appetite, and this later function seems important for one of the claimed medical benefits in offsetting the effects of the chronic wasting syndrome in AIDS and the prolonged nausea that accompanies chemotherapy. (...) Because the drug is usually smoked, it has acute and chronic effects that are shared with tobacco. These include airway irritation, cough, and probably with chronic use, bronchitis, chronic obstructive pulmonary disease, and lung and pharyngeal cancers. Its impact on the immune system is generally to impair the function of the immune system, but the impact on human health of this impairment is probably minor. (...) The effects of cannabis consumption on reproductive health are negative in animal studies. (...) This obviously has some relevance to human health. However, human studies have yet to show any measurable adverse impact beyond some evidence of adverse behavioural and developmental impacts on the children of mothers who smoked cannabis heavily during pregnancy. (...) The impact of cannabis on cognition is well documented. Short-term memory is adversely affected and chronic use may lead to chronic measurable defects in cognitive functioning. However, this may be more the result of persistent chronic intoxication than impairment in the substance and the working of the brain. Psychomotor skills are adversely affected by cannabis use. Driving or operating heavy machinery when intoxicated is contraindicated. Again, in contradistinction to alcohol, cannabis intoxication tends to slow drivers down rather than increase their speeds. Similarly, cannabis smokers tend not to be involved in acts of physical violence and aggression, and violence and aggression when intoxicated is reportedly very rare. Cannabis use may provoke schizophrenic symptoms in those with active schizophrenia or schizophrenic tendencies. Panic attacks and dysphoria are also mentioned in the literature. There is an amotivational syndrome described in the literature and cannabis is said to induce it, but most researchers have discredited that over the last decade. (...) Concerns have legitimately been raised about the effects of cannabis consumption on adolescent development. As use tends to peak in late adolescence, this is an important consideration. The adverse effects that have been noted include an association with risk of discontinuation of high school, job instability and progression to the use of harder drugs. The degree to which these associations are causal is very controversial. Alternative hypotheses are that cannabis use, like adolescent alcohol use, early onset of sexual activity, and tobacco smoking, are in fact markers for other risks of adverse social conditions (...) All researchers agree, however, that intoxication interferes with academic prowess. Recent studies seem to demonstrate measurable though reversible drops in IQ associated with

[13] Dr. Benedikt Fischer, Professor, Department of Public Health Sciences, University of Toronto, Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, September 7, 2001, Issue No. 6, page 9.

heavy, persistent cannabis use and that engagement in illicit activities carries substantial risks, especially perhaps for youth whose connections to the school community are tenuous at best. [14]

I would like to first focus on the acute effects and then on the chronic effects. "Acute effects" are those effects that you experience during the course of action of a single dose. In the nervous system that includes a period of several hours in which (...) you become "chemically stupid." Side effects include decreased arousal and drowsiness, which acts together with the drowsiness produced by alcohol and other central nervous system depressants. Other side effects are impaired short-term memory, slowed reactions, less accuracy in test performance and less selectivity of attention. (...) Low doses generally produce the effects that cause people to like smoking pot. They include mild euphoria, relaxation, increased sociability and a non-specific decrease in anxiety. However, high doses produce a bad mood, anxiety and depression. There can be increased anxiety to the point of panic or even an acute toxic psychosis which, fortunately, is of very short duration and goes away when the drug effect wears off. High doses cause impaired motor coordination, unsteadiness of control and decreased muscle tone, which is therapeutically useful. (...) With low doses, perception is enhanced. That is part of the pleasure. In high doses, the same action produces sensory distortion, hallucinations and the acute toxic psychosis to which I have already referred. (...) It does not seriously affect the cardiovascular system. (...) As to chronic effects, in the central nervous system there is impaired memory, vagueness of thought, decreased verbal fluency, and learning deficits in chronic, heavy users. I emphasize "heavy" because the social user does not, by and large, show any significant health effects. Neither does the social user of alcohol. (...) These effects on cognitive functions fortunately tend to go away if the heavy user stops, for whatever reason. As long as use continues, there is a chronic intoxication, apathy, confusion, muddled thinking, depression, and sometimes paranoia. (...) Cannabis dependence, as defined in the conventional diagnostic criteria for dependence as set out in the latest edition of the American Psychiatric Association, or the equivalent publication of the World Health Organization, has been well documented in regular, heavy users. Numerous studies now show that a significant percentage of regular users are dependent. In some studies in Australia of long-term heavy users, mainly daily users for periods of 15, 17, 20 years, 60 per cent or more of them met the diagnostic criteria (...). Tolerance has been shown. By and large, it is not a terribly serious effect, and the physical withdrawal syndrome is not severe. Nevertheless, it is there, which indicates that physical dependence, in addition to psychological dependence, occurs as well. [15]

The long-term chronic effects of cannabis essentially cause the following symptoms: memory loss, faulty attention and concentration, a slow-motivation syndrome of passivity and low initiative, increased risk of respiratory disease, more specifically asthma, bronchitis and emphysema and a higher risk of cancer. (...) There may be hormone problems causing low fertility in men and women. In men, this can cause the development of breasts which is very unesthetic (...). Finally, in the long-term, it can also cause lower resistance to infectious disease. [16]

---

[14] Dr. Perry Kendall, Health Officer for the Province of British Columbia, Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, September 17, 2001, Issue No. 6, pages 33-33.

[15] Dr. Harold Kalant, Professor Emeritus at the University of Toronto, Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, June 11, 2001, Issue No. 4, pages 74-76.

[16] Dr. Mohamed ben Amar, Professor of Pharmacology and Toxicology, University of Montreal, Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, June 11, 2001, Issue No. 4, pages 9-10.

As we can see, opinions sometimes agree and often differ. They agree at least on the nature of the consequences that may be of concern. One by one, we have seen effects that were physiological (risks of cancer, effects on reproduction and the immune system, deterioration of brain cells), effects that were psychological (amotivational syndrome, risks of psychosis, impaired cognitive function and memory in particular), and effects that were social (affecting the family and work, as well as the ability to drive vehicles and operate machinery). Opinions differ primarily on the scope of the conclusions that can be drawn from this knowledge. To what extent, in fact, can we generalize about the effects we observe in often small and rarely random samples of subjects? Also, to what extent can we generalize about the data on chronic users who represent – as we saw in the previous chapter – only a small percentage of cannabis users? And especially, to what extent does this data allow us to establish causal relationships?

The Committee also finds that most witnesses stressed the negative aspects and rarely the positive. However, if people use drugs in general, and cannabis in particular, surely it isn't just to destroy themselves or because these drugs have only negative effects. Given the limitations of making any comparison between substances, we can still draw a parallel with alcohol: most of us know the pleasure of sharing a glass of wine with friends over a good meal, just as we also know the dangers of alcohol abuse and alcoholism. The Committee also notes that it is difficult, even for the most experienced researchers, to sift through the knowledge without assigning it a valence relative to the direction public policy should take. The same knowledge may be interpreted negatively here and more moderately there, based on the interpreter's preconceptions of the "best" choice for public policy. We are not immune to this bias. Moreover, we do not deny that we had preconceptions, derived from our personal histories, our reading, and the hearings we held in 1996 to review Canada's drug legislation. Among these preconceptions, which oriented our reading of the testimony, at least at first, we note:

- The conviction that the current system does not achieve its objectives, if only because of the increase in cannabis use, by young people in particular;
- A preference for an approach that is more consensual and more in keeping with Canadian attitudes;
- A preference for a harm-reduction approach as indicated by the wording of our first mandate;
- A tendency to distinguish between soft drugs – including cannabis – and hard drugs (heroin, cocaine);
- A certain lack of knowledge about the specific effects of cannabis, from the standpoint of the toxicological and pharmacological studies conducted in recent years.

This being said, we did not work in isolation. Not only were we accompanied by our research team – sociologists, lawyers, criminologists – throughout our work, not only were we also under the close surveillance of the witnesses in a way and of the public in a larger sense, but primarily, other committees, in other countries, have conducted similar reviews in recent years. Their work was a source of inspiration and knowledge and as well a benchmark against which to compare our own conclusions.

ACUTE EFFECTS OF CANNABIS

In toxicology, acute effects are those that are produced immediately after use and while the psychoactive effects are being experienced. These effects also correspond to what has been called cannabis intoxication ever since Moreau de Tours in 1845.[17] The "real" effects – on biological systems – and the effects experienced by users can vary based on a set of factors, such as the user's experience with cannabis and other drugs (including tobacco), the user's expectations and the context of use. In fact, [translation] *"the psychoactive effects of cannabis, more than any other substance, vary from one subject to another and, for the same subject, from one experience to another."*[18] Additionally, with no reliable method to measure THC content in plasma, it is difficult to link the duration and strength of effects to the various cannabis preparations, in particular because of variations in the composition of the substance and in the bioavailability of THC. It is even more difficult to attribute relatively rare effects (for example, the appearance of psychotic symptoms) insofar as it is hard to decide if the co-occurrence is coincidental, if these effects stem from other substances often associated with cannabis use or from very high doses of cannabis, or from interactions between these various factors.[19]

The acute effects of cannabis are relatively well documented. Research sometimes distinguishes between central and peripheral effects[20], sometimes between somatic effects and psychological or psychomotor effects[21], and sometimes is simply content to list the effects of one type or another.[22]

Cannabis intoxication is generally considered to consist of two main phases:

[17] Moreau de Tours, J., *Du haschich ou de l'aliénation mentale, étude psychologique*. Paris: Masson.
[18] INSERM, *op. cit.*, page 118.
[19] See WHO, 1997, *op. cit.*, 3.
[20] For example, this is the case with the classification proposed by Ben Amar (at press).
[21] This is the case with the collective expertise of INSERM (2001).
[22] This is the case with most works: WHO, 1997; Swiss Federal Commission for Drug Issues (1999) *Rapport sur le cannabis*. Berne: Swiss Federal Office of Public Health; and the report by Wheelock (2002).

- The first phase, the "high", includes the following effects:
  - A change in general mood, accompanied by gaiety or even hilarity, talkativeness, and a carefree feeling
  - A change in physical experience, including a feeling of well-being and satisfaction, a feeling of calm and relaxation, sociability
  - Alteration of intellectual functions, including increased self-confidence, magical thinking (feeling of being able to perform tasks more easily), distorted perception of time, space and self-image
  - Sensory changes, marked by increased sensory perceptions (colours, sounds sometimes seem more intense), stronger tactile impressions.

- The second phase, "coming down", is characterized by a feeling of sluggishness or drowsiness that appears gradually a little while after use.

More specifically, depending on their type of action, a distinction is made between truly somatic effects and more psychological ones.

- Somatic Effects:
  - Cardiovascular effects: approximately 10 minutes after use, heart rate, cardiac output and cerebral blood flow increase. Tachycardia (accelerated heart rate) can achieve increases of 20% to 50% compared to normal rhythm and could help trigger anxiety and panic attacks in some subjects. It can be responsible for palpitations, reduced exercise tolerance in subjects with heart conditions, and can even facilitate the development of heart problems in subjects who are at risk or are predisposed. A recent study suggests that the risk of myocardial infarction increases by 4.8 times in the first hour after using marijuana and is 1.7 times higher in the second hour, thus suggesting that cannabis may represent a risk in the 60 minutes following its use. Hypotension while the subject is lying down is also mentioned. These effects vary based on the dose and concentration of THC.
  - Bronchopulmonary effects: the effects are similar to those of tobacco. Bronchodilator activity in the 60 minutes following use is mentioned. However this does not prevent the inflammatory consequences of smoking cannabis nor the secondary bronchial hyperreactivity that is translated in particular by a cough that results from the action of the THC and the irritating potential of the products of combustion;
  - Ocular effects: redness of the eyes due to vasodilation and conjunctival irritation is mentioned;

- Other somatic effects: dry mouth due to decreased saliva secretion, increased appetite due to hypoglycemia (drop in blood sugar level), and more rarely nausea and vomiting, diarrhea and urine retention.

❖ Psychological and Psychomotor Effects:

- Diminished short term memory (so-called "working" memory): remembering words, pictures, stories and sounds;
- Disturbances in psychomotor performance, including diminished ability to pay attention and concentrate, diminished reflexes, slowed reaction time, problems with coordination of movements, and impaired and diminished ability to perform complex tasks. Thus, a study by Fant et al. describes diminished visual tracking in the central and peripheral fields of vision after 15 minutes, capable of lasting for more than 5 hours.[23] Moreover, we note that according to professor Roques, studies on the effects of cannabis on learning abilities, in particular short term memory and working memory, are open to criticism from the standpoint of methodology and their contradictory results, "*the heaviest users were the least affected*".[24] [translation]

Somatic, cognitive and psychomotor effects are related to the amount of cannabis inhaled and the concentration of THC. Thus, according to INSERM:

> *A quantity that corresponds to 25 puffs impairs psychomotor skills and cognitive performance, and more markedly than consumption of 10 puffs or 4 puffs. Maximum plasma levels then rise from 57 ng/ml (for 4 puffs from a cigarette containing 1.75% Δ^9THC) to 268 ng/ml (for 25 puffs from a cigarette containing 3.55% Δ^9THC). Heishman et al. (1997) established an approximate equivalence between 16 puffs at 3.55 % Δ^9THC and approximately 70g of alcohol. At these levels, memory, cognitive and psychomotor performance and mood are impaired.*[25] [translation]

The cognitive and psychomotor effects may continue for more than five hours, and some cognitive impairment may extend for 24 hours.

At high doses, or with inexperienced users, cannabis may cause a certain number of negative reactions that can even include a genuine paranoid, hallucinatory, manic or hypomanic psychotic experience. However these experiences are brief. Some disorders documented with high doses include:

---

[23] Fant, R.V. et al. (1998) "Acute and residual effects of marijuana in humans." *Pharmacology, Biochemistry and Behavior*, 60: 777-784.

[24] Roques, B. (1999) *La dangerosité des drogues.* Paris: Odile Jacob, page: 184.

[25] INSERM, *op. cit.*, page: 203.

- Anxiety, even panic attacks
- Confusion or disorientation
- Vertigo, nausea or vomiting
- Convulsions
- Depersonalization
- Hallucinations
- Paranoia
- Acute psychosis

These phenomena are relatively rare (less than 1 in a thousand psychiatric admissions). Primarily, it is difficult to establish that cannabis was the cause. In fact, in most cases, the most likely hypothesis is that these subjects were already predisposed, or had even already had psychotic or schizophrenic experiences. Use of other substances, alcohol, other illicit drugs, or medications, could also play an important role.

> *The link between cannabis use and psychosis is a very controversial issue. At the moment, we lack a corpus of comparable, methodologically sound studies repeatedly yielding similar conclusions. The results of existing studies are often complex or ambiguous and the personal opinions of the researchers often interfere with the interpretations. Further deepening our scientific knowledge is still necessary. However, there is extensive, albeit incomplete, consensus on the ability of heavy cannabis consumption or intoxication to induce an acute transitory psychotic state in healthy subjects. The frequency of this condition is unknown and the mechanisms are hypothetical.*[26]

In accordance with the collective expertise of INSERM, we can establish the following:

> *The psychotic disorders caused by cannabis use are brief psychotic episodes that last less than two months, even four months[sic], sometimes a week. The premorbid personality does not present a pathological aspect. Regular users are at greater risk than occasional users. Onset is abrupt, in two or three days, with or without a recent increase in the use of toxic agents, sometimes with a psychological or somatic precipitating factor. Some symptoms appear more specific: behavioural problems, aggression, visual hallucinations, polymorphic nature of the delirium along various themes, psychomotor disinhibition. (...) Compared to a schizophrenic disorder, subjects are younger, 20 to 30 years of age rather than 25 to 30, with a greater proportion of poorly socialized males.*[27] [translation]

---

[26] Hanak, C. et al. (2002) "Cannabis, mental health and dependence." in Pelc, I. (ed.), *International Scientific Conference on Cannabis*, Brussels.

[27] INSERM, *op. cit.*, page 124.

However, here too, the data are relatively contradictory and, according to professor Roques, there is support for the belief that usage is more widespread among people with previous mental disorders.[28]

CONSEQUENCES OF CHRONIC USE

Most of the works consulted in pharmacology, toxicology and psychiatry speak of chronic effects. For our part, we prefer to speak of *consequences* resulting from chronic use. There are two reasons for this. First of all, because these consequences result not so much from the substance itself as from the way it is used. Therefore we are not dealing with the effects of the substance, but rather with the consequences that may arise from repeated, or even heavy, use. The second reason is that, as we saw in Chapter 6, chronic cannabis users account for a small fraction (often less than 10%) of lifetime users of cannabis. As a result, the consequences in question in this section concern this small portion of the population of users and not the substance itself.

We feel this distinction is fundamental because it is common, at all levels of public discussion – whether involving politicians, the public at large, or experts – to blame the substance – here cannabis, there alcohol or medications, even other illicit drugs–when in fact we must *learn to distinguish between patterns and methods of use*. By that we mean at-risk behaviour, which varies with the substance of course, and which does not depend solely on the intrinsic properties of the substance, but stems, in an overall approach, from the relationship between the substance and its place in society (integrated or not) from the individual's characteristics, and from the society in which the substance is used.[29] Of course by that it should be clear that ***we consider as separate, for cannabis as for alcohol, use, at-risk use and heavy use*** (or abuse)[30], and that we reject the equivalency often made between use and abuse where any form of use is perceived as abuse. At the same time, we are aware of the vagueness that continues to surround these various types of behaviour – or practices – and that there is no clearly defined boundary, even less a universal boundary, between use, harmful use and dependence. For the purposes of this chapter, the consequences in question in the following three sections refer, without being more specific, to chronic use (which then includes at-risk and heavy use).

---

[28] Roques, B., *op. cit.*, page 186.

[29] This question has been discussed more fully in Chapter 6. For now it is enough to refer the reader to the work of Reynaud et al. (1999) *Les pratiques addictives. Usage, usage nocif et dépendance aux substances psycho-actives.* Paris: La Documentation française.

[30] We will more clearly establish the parameters we used to make this distinction in the next chapter on use and users. Further on in this chapter we will see that dependence is a consequence of heavy use.

Physiological consequences of chronic use

The main physiological consequences of the chronic use of cannabis dealt with in scientific literature concern the respiratory system and the carcinogenicity of cannabis, the immune system, the endocrine system and reproductive functions and, to a lesser degree, the cardiovascular system.

Consequences for the respiratory system

Except for the nicotine in tobacco and the cannabinoids in cannabis, the smoke of these two products shares common irritating, even carcinogenic, properties. Although not recent, a comparative analysis of these products has shown that the concentration of certain strongly carcinogenic ingredients such as benzopyrene and benzanthracene is higher in cannabis smoke than tobacco smoke.[31] A more recent study cited by INSERM confirms this higher concentration of benzopyrene: 2.9 micrograms/100 joints compared to 1.7 for 100 cigarettes.[32] Of course, it will be argued that tobacco users generally smoke many more cigarettes a day than even chronic users of marijuana, that it is the total volume of toxic substances inhaled over time that counts, and that it can be difficult to distinguish the effects of cannabis from those of tobacco since joints often contain both products and users of cannabis are also often tobacco smokers.[33]

However we note other worrisome characteristics with respect to the potential effects on the respiratory tract of smoking cannabis. First of all, the concentration of benzopyrene in marijuana tar is 70% higher than that in the same weight of tobacco tar. Furthermore, an equal product weight of cannabis provides up to 4 times more tar than a strong tobacco. According to a study cited by INSERM, tar from a joint varies between 40 and 56 mg/cigarette whereas the allowable dose for a European tobacco cigarette is 12 mg.[34] In addition, a marijuana cigarette is generally smoked much more completely than a tobacco cigarette, inhalation – an important part of the ritual – is deeper and the smoke is held in the lungs longer and the combustion temperature of cannabis is higher than that of tobacco. Consequently, the percentage of tar deposited in the lungs is higher after smoking cannabis (> 80%) than after inhaling tobacco (64%) and the deposits are even greater for cannabis with a lower concentration of THC, probably because smokers draw on the joint more.[35]

According to INSERM's report, chronic use of cannabis *"results in unquestionable bronchial disorders (...) chronic bronchitis with a chronic cough, expectorations and a sibilant rale"*[36] [translation], a conclusion shared by the Institute of Medicine in the United States in its

---

[31] Institute of Medicine (1982) *Marihuana and Health.* Washington, DC: National Academy of Sciences.

[32] INSERM (2001), op. cit., page 222.

[33] For example, those are the criticisms made by Zimmer L., and J.P. Morgan (2000 for the French version; 1997 for the American original) *Marijuana. Mythes et réalités.* Paris: Georg editor.

[34] *Ibid.*, page 221.

[35] *Ibid.*, page 221

[36] *Ibid.*, page 218.

recent report on marijuana[37] as well as by the WHO.[38] Moreover, macrophages (cells that attack foreign bodies) in the pulmonary alveoli seem to lose their ability to neutralize bacteria when exposed to cannabis smoke, hence the greater susceptibility of the bronchi and lungs to bacterial infections. According to some authors, in theory, a cannabis cigarette could cause as much damage as 4 to 10 tobacco cigarettes.[39] This data on the reduced ability of alveolar macrophages to destroy bacteria also suggests that cannabis could have an immunosuppressive action that decreases the ability of the organism, here the lungs, to fight carcinogenic cells.

The work of Tashkin in particular, but also of other researchers, is not as confirmatory on the effects of cannabis on the respiratory tract. Thus a recent study by Tashkin on heavy cannabis smokers showed that there was no decrease in the forced expiratory volume in one second to vital capacity ratio, even for those who smoked 3 joints a day, compared to tobacco smokers who registered a significant decrease.[40] Tashkin's team also questioned the development of emphysema in cannabis users and bronchiole obstruction.[41] Similarly, a study by the *Kaiser Permanent Medical Care Program* revealed that daily cannabis users who did not use tobacco were hardly more likely than non-smokers (36% vs. 33%) to consult for colds, the flu and bronchitis.[42] We also note that to date, studies are contradictory about the additivity of the effects of tobacco and cannabis.

Carcinogenic potential

With respect to the carcinogenic potential of cannabis, there is a distinction between the carcinogenic effects of cannabis smoke – a potential source of lung cancer in particular – and the mutagenic effects of THC on cells. According to the majority of authors, THC itself does not seem to be carcinogenic.[43] However, cannabis smoke, like tobacco smoke, does seem to be able to increase the incidence of cancerous tumors.

The work of Fliegel[44] indicates that the histological changes that are considered the precursors of carcinomata are present in chronic smokers of cannabis. This data is

---

[37] Joy, J.E. et al., (1999) *Marijuana and Medicine: Assessing the Science Base.* Washington, DC: Institute of Medicine.

[38] WHO (1997) *op. cit.*

[39] Ben Amar (at press), *op. cit.*, page 18.

[40] Tashkin, D.P. et al., (1997) "Heavy habitual marijuana smoking does not cause an accelerated decline in FEV1 with age: a longitudinal study." *American Journal of Respiratory Critical Care*, 155: 141-148.

[41] See Zimmer and Morgan, op. cit., page 148.

[42] Polen, M.R. (1993) "Health care use by frequent marijuana smokers who do not smoke tobacco." *Western Journal of Medicine*, 158: 596-601.

[43] In particular, see the conclusions of INSERM (2001), op. cit.; as well as the report by Wheelock (2002) *op. cit.* for the Senate Committee.

[44] Fliegel S.E.G. et al., (1988) "Pulmonary pathology in marijuana smokers", in Chesher G. et al. (eds.), *Marijuana: An International Research Report*, National Campaign Against Drug Abuse, Monograph 7, 43-48, Canberra, Australian Government Publishing Service; and Fliegel, SEG et al., (1997) "Tracheo-bronchial histopathology in habitual smokers of cocaine, marijuana or tobacco" *Chest*, 112: 319-326.

also supported by clinical cases of cancers of the upper aerodigestive tract in young adult cannabis smokers. These cancers are types rarely observed in young subjects. Namely:

- Thirteen cases of brain and neck cancer in young adults under the age of forty, eleven of whom were daily cannabis smokers;[45]
- Ten cases of cancers of the upper respiratory tract in young adults under the age of forty, seven of whom were probable regular users of cannabis;[46] and
- Two cases of carcinoma of the tongue in men between 37 and 52 years of age for whom the only common risk factor was the regular and daily use of cannabis.[47]

We note first of all the small number of cases, especially when compared to the large number of cannabis users. These clinical cases also present a certain number of important limitations: none compares the prevalence of cancer with a control group or evaluates the use of cannabis in a standardized way. Interpretation is also limited by the fact that the patients also smoked tobacco and drank alcohol.

The data available seems to indicate that the consequences of chronic and intense cannabis use (several joints per day for several years) are similar to those of cigarettes in terms of carcinogenic risks for the respiratory tract as well as the mouth, the tongue and the esophagus.[48] THC is generally considered to alter the functions of certain cells, namely lymphocytes, macrophages and polymorphonuclear cells, especially in *in vitro* models. However conducting controlled studies is largely recognized as a research priority in this field.[49]

Consequences for the immune system

Apart from the possible consequences for the respiratory tract defense system essentially caused by smoke, there is no conclusive data regarding the effects of cannabis on the immune system. Some studies on rodents show that high levels of cannabinoids, including THC, alter cellular immunity. In some cases, the experimental activity of cannabinoids is immunosuppressive and in others it is stimulating. These

---

45 Donald P.J. (1991) "Marijuana and upper aerodigestive tract malignancy in young patients", in Nahas, G. and C. Latour (eds.), *Physiopathology of Illicit Drugs: Cannabis, Cocaine, Opiates*, 39-54, Oxford; and (1991) "Advanced malignancy in the young marijuana smoker", in Friedman, H. et al., (eds.), *Drugs of Abuse, Immunity and Immunodeficiency*, 33-36, London.

46 Taylor, F.M. (1988) "Marijuana as a potential respiratory tract carcinogen: A retrospective analysis of a community hospital population", *Southern Medical Journal* 81: 1213-1216.

47 Caplan, G.A. and B.A. Brigham (1990) "Marijuana smoking and carcinoma of the tongue: Is there an association?" *Cancer* 66: 1005-1006.

48 MacPhee, D., (1999) "Effects of marijuana on cell nuclei", in Kalant, H. et al. (eds.), *The Health Effects of Cannabis*, Toronto: Addiction Research Foundation.

49 In particular WHO (1997), op. cit.; Hall, W. and N. Solowij (1998) "Adverse effects of cannabis" *The Lancet*, 352, no. 9140, page 6; INSERM (2001), *op. cit.*

variations depend on experimental factors such as the concentration of the substance, the time and duration of administration, and the type of cell function studied. Very little work has been done on humans. According to the WHO report, if it is clear that cannabinoids have immunomodulating effects, it is also clear that the immune system is resistant to this substance. Several of the effects are relatively minimal and completely reversible, and are only experienced at higher doses than those required for the drug's psychoactive effect in humans. Lastly, still according to the WHO report, even with respect to the immunomodulating effects of cannabis smoke, the studies are not conclusive and it is hard to compare the doses used in experiments with animals to the doses used by humans. The report concludes that rigorous studies on this question are necessary.[50]

Consequences for the endocrine system and reproduction

Endocrine abnormalities are well documented in animals. In the male rat, decreased testosterone secretion with testicular atrophy, impaired production, mobility and viability of sperm, and changes in sexual behaviour have been noted with high doses. The ovulatory cycle of the female is altered. In humans, the results are contradictory, in particular because findings are not constant from one study to another, but also because similar changes occur following the absorption of prescription drugs. Furthermore, the changes observed are often borderline normal and their clinical consequences remain controversial.[51]

With respect to reproduction, the fact that the active ingredients in cannabis cross the placental barrier is well established. Nevertheless, the question of the potential effects of cannabis on the feotus is far from resolved, especially since the studies are methodologically poor. Thus, when studying pregnant women who are cannabis users, the women often come from low socio-economic backgrounds – and we know that socio-economic level is a determining factor in the size and weight of babies – and it is difficult to isolate the effect of other factors, including the use of tobacco and alcohol – which we know are risk factors for premature birth, lower weight and smaller size. In fact, studies on occasional cannabis smokers do not show any significant difference with respect to non-smokers. All in all, most studies did not observe any significant differences.[52] Nevertheless, reports from the WHO and the collective expertise of INSERM conclude that, despite methodological difficulties, there is reasonable evidence that cannabis use during pregnancy harms fetal development, in particular restricted growth and behavioural abnormalities, but that these abnormalities are rather minor.[53]

As for the neonatal consequences of cannabis use by mothers during pregnancy, longitudinal studies on cohorts of children conducted in Ottawa since 1978 by

[50] WHO (1997), *op. cit.*, page 26.

[51] INSERM (2001), *op. cit.*, page 219-220.

[52] Wheelock, B. (2002), *op. cit.*, page 29.

[53] WHO (1997), *op. cit.*, page: 24; INSERM, *op. cit.*, page 237.

psychologist Peter Fried's team[54] are not conclusive. All the measurements taken reveal more similarities than differences between the children of smokers and non-smokers. And when differences are observed, they are minor and it is impossible to dissociate the effects of the various substances, tobacco and alcohol in particular. Lastly, these studies involve a small sample of children and generalizations cannot be drawn from them. Another longitudinal study, reported by INSERM, involving 636 subjects, concluded [translation] "*there is a significant relationship between behavioural problems at age 10 and prenatal exposure to cannabis.*" However the report from INSERM also notes that [translation] "*if the results from these two studies seem to converge well (...) we must remember nevertheless that the postnatal environment can play an important role in the continuation of behavioural abnormalities.*"[55]

Consequences for the cardiovascular system

Chronic use of cannabis may lead to cardiovascular complications for predisposed individuals. In fact, the use of significant quantities can slow the heart rate. Also, cannabis can have similar effects to those of tobacco on heart function by increasing the muscle workload. Furthermore, some studies point out the role that the carbon monoxide found in cannabis smoke plays in the risk of cardiovascular complications.

Cognitive and psychological consequences

The main cognitive and psychological consequences of chronic cannabis use concern brain functions involved in memory and verbal and math skills; motivation; and psychiatric disorders.

Brain functions

We have seen that cannabis has acute effects on short-term memory, attention and concentration. Does chronic use eventually result in effects on cognitive function that may be irreversible? These questions first raise the question of the neurotoxicity of cannabis, defined as "*a reversible or irreversible impairment of the structure and/or functions of the central (and/or peripheral) nervous system by physical, chemical or biological agents*"[56] [translation]

According to professor Roques:

> [translation] *Cannabis dependence does not result in neurotoxicity (...). Thus old results suggesting anatomical changes in the brain of chronic cannabis users, as measured by tomography, have not been confirmed by precise modern techniques of neuro-imaging. Similarly, morphological changes in the hippocampus of the rat following administration of very high doses of THC (Landfield et al., 1988) have not been repeated (Slikker et al., 1992). (...) Several studies have been devoted to the effects of*

[54] Fried, P.A. (1995) "Prenatal exposure to marijuana and tobacco during infancy, early and middle childhood: Effects and attempts at a synthesis." *Archives of Toxicology*, 17; and Fried P.A. and B. Watkinson (1999) "36- and 48-month neurobehavioral follow-up of children prenatally exposed to marijuana, cigarettes and alcohol." *Journal of Deviant Behavior and Pediatrics.* 11: 49-58.

[55] INSERM (2001) *op. cit.*, page 235.

[56] Roques, B., (1999) *op. cit.*, page 73.

> *cannabis on evoked responses and on electroencephalograms of humans. Intermittent use produces reversible changes in* α *wave patterns in the frontal cortex, probably with respect to the state of drowsiness induced by* THC. *In the very long term (more than fifteen years) and with heavy daily use,* δ *hyperfrontality and an increase in* θ *frontal activity have been observed (Struve et al., 1990, 1994). The possible connection with behavioural changes and changes in neuropsychological tests is not in question, nor moreover is that which is possible with the anticonvulsive effects of* THC.[57]

The results of studies reported by the collective expertise of INSERM are contradictory as some observe changes while others do not. Even when changes are observed, they are often of minor amplitude and are reversible after a period of abstinence. The INSERM report observes that studies using neuro-imaging techniques have not confirmed the neurotoxicity of cannabis in either man or baboon.[58] Therefore it is through observing functioning and behaviour that we are still best able to examine the question of the neurological effects of cannabis.

Unfortunately, studies are just as contradictory here and the results are inconclusive. Studies performed in the 1970s in countries where cannabis use is traditional (Jamaica, Costa Rica, India) did not point out any significant differences in cognitive functions of users and non-users, whereas more recent studies, in particular in Costa Rica in the 1980s, did show differences: [translation] *"In particular, long-term users recalled fewer words on a list they had been shown earlier and response time was longer.*"[59] In the United States, studies conducted in the 1970s found contradictory results for memory functions, whereas more recent studies reported subtle deficits in cognitive functions of heavy users after a brief period of abstinence. Some studies also showed continued memory impairment in adolescents after six weeks of abstinence.[60]

Most studies tend to show that overall, ex-users recover all cognitive functions, but depending on the length of use, subtle impairments can persist, in particular with regard to the ability to process complex information.

Still according to the collective expertise of INSERM, the age when use begins can be a determining factor. Thus, a recent study shows the persistence of some visual scanning impairments (related to attention) in young people who began to use cannabis before age 16, whereas those who began use after age 16 show no difference from non-users.[61]

In all, we cannot really establish that cannabis use has negative consequences for brain functions, even in chronic users, unless use begins before age 16.

Motivation

Some studies suggest the presence of an amotivational syndrome in chronic cannabis users, a syndrome that could affect the performance of young people at

---

57 Roques, B., (1999) *op. cit.*, page 187.

58 INSERM, *op. cit.*, page 206.

59 *Ibid.*, page 204.

60 *Ibid.*, page 205.

61 *Ibid.*, page 206.

school and employees in a professional environment in particular. In its 1997 report, the WHO pointed out that our knowledge has not advanced since its previous report in 1981: the amotivational syndrome has still not been clearly defined, its effects have still not been clearly distinguished from the effects of intoxication itself, and the data available comes from clinical case reports with no control group.[62]

In order to evaluate the impact of cannabis on motivation, Canadian researchers developed a study where subjects received cannabis in exchange for work performed. Even though it is not recent, the study is no less interesting. They observed that subjects worked less efficiently immediately after using cannabis. However, their level of productivity then increased rapidly and exceeded levels achieved during periods of abstinence. Although working fewer hours, the subjects using cannabis were not less productive because they worked harder. Furthermore, over the course of the period of heaviest use, the subjects organized a strike and successfully negotiated a "salary" increase, after which they worked even harder.[63] [64]

Studies do not enable us to establish if motivational problems, when observed, preceded or followed cannabis use, or if other emotional or psychosocial factors played a greater role, or were even determining factors in the chronic use or abuse of cannabis in young people in particular. These conclusions are shared by the collective expertise of INSERM and by the authors of the report submitted to the International Scientific Conference on Cannabis in March 2002.[65]

Psychiatric disorders

Various psychiatric disorders have been associated with chronic cannabis use: mood disorders and depressive episodes, anxiety disorders, personality disorders, as well as more severe conditions, such as psychoses and schizophrenia. For each of these situations, the conclusion drawn by the authors of the report on mental health and cannabis prepared for the International Scientific Conference on Cannabis generally applies:

> *There are three possible ways to account for the relationship between cannabis and mood disorders. First, both may share common risk factors, so that their relationship is not causal. Second, mood disorders may predispose people to use cannabis. Third, cannabis use may trigger or increase depressive symptoms. As yet, there is no clear answer to this question of "which comes first".* [66]

---

[62] WHO (1997), *op. cit.*, page 18.

[63] Miles G.C. et al., (1974) *An Experimental Study of the Effects of Daily Cannabis Smoking on Behavioural Patterns*, Toronto: Addiction Research Foundation, Toronto.

[64] Campbell, I. (1976) *The Amotivational Syndrome and Cannabis Use With Emphasis on the Canadian Scene*, Annals of the New York Academy of Sciences 282, 33-36.

[65] INSERM, *op. cit.*; Hanak, C. et al., (2002) "Cannabis, mental health and dependence", Pelc, I. (ed.), *International Scientific Conference on Cannabis*, *op. cit.*, page 61.

[66] Hanak, C. et al. (2002), *op. cit.*, page 62.

Specifically with regard to mood disorders, depressive states and anxiety disorders, it seems probable that they precede chronic use. However, study results are extremely disparate: for mood disorders in so-called dependent people, the prevalence varies (depending on study methods), from 10% to almost 50%; with respect to major depressive episodes in clinical populations, studies report percentages varying from 4% to almost 20%. INSERM's report presents a review that we feel is much more enlightening with regard to the situation for adolescents:

> [Translation] *Acquiring new knowledge has allowed for a better assessment of the burden of "early onset depression" in terms of individual suffering and public health. Its prevalence, around 5% in adolescence, makes it one of the most common pathologies for this period. The risk of suicide is high, and the functional deficits inherent in depressive syndromes are a source of school and family problems, and cause withdrawal from peers, for which the psychosocial consequences can be severe, especially if the disorder is prolonged. Additionally, depression is rarely an isolated disorder in a young subject: anxiety or behavioural disorders often precede or accompany depressive episodes and can survive them; moreover, the existence of a depressive disorder is a risk factor for addiction (alcohol or any other psychoactive substance) and eating disorders.* [67]

With respect to psychotic disorders and schizophrenia, the two subjects are controversial, the methodologies weak, the data contradictory and the interpretations are often based on simplistic models of causality. If, in certain circumstances, cannabis can trigger psychotic episodes, they are most often short and resolve rapidly. As for schizophrenia, if it is true that cannabis use is more prevalent in these subjects than in the general population, some feel that it is self-medicating behaviour while others feel that the chronic use of cannabis is a trigger for the schizophrenic process. We feel that the conclusion of professor Roques' report agrees best with current data:

> [Translation] *No mental pathology directly related to the overuse of cannabis has been reported, which distinguishes this substance from psychostimulants such as MDXA, cocaine or alcohol, heavy and repeated use of which can give rise to characteristic psychotic syndromes. Similarly, cannabis does not seem to precipitate the onset of pre-existing mental dysfunctions (schizophrenia, bipolar depression, etc.).* [68]

As it is, most scientific reports come to the same conclusion: more research is needed, with more rigorous protocols, allowing in particular for comparison with other populations and other substances.

Behavioural and social consequences

The main behavioural and social consequences examined in scientific literature deal with social and family adjustment, aggression, and the ability to perform complex tasks.

---

[67] INSERM (2001), *op. cit.*, page 98.

[68] Roques, B., (1999) *op. cit.*, page 186.

Social and family adjustment

According to some studies, chronic cannabis use could have consequences for social and family adjustment. Thus chronic users would have more difficulty keeping a job, would be unemployed more often and would have more interpersonal adjustment problems.[69]

However, most of these studies suffer from methodological problems and interpretation difficulties. Most studies involve samples of people who, by and large, come from underprivileged socio-economic backgrounds. Above all, beyond the statistical association, it is difficult to determine to what extent other factors play a preponderant role, of which cannabis is itself a symptom and not a cause.

Aggression

Unlike other psychoactive substances, alcohol and cocaine in particular, cannabis does not lead to aggression. When examining withdrawal symptoms once dependence is established, some authors note greater irritability; but this is even less significant proportionally than that caused by tobacco.

Performing complex tasks

No study on chronic cannabis use has been able to establish that cannabis causes long-term effects on the ability to perform complex tasks. This data is in keeping with cannabis' lack of neurotoxicity.

TOLERANCE AND DEPENDENCE

When we think drugs we think drug addiction since, as F. Caballero states, a drug is [translation] "*any substance likely to lead to addiction*".[70] In France and Europe, monitoring groups created in recent years are called monitoring centres for drugs and drug addiction. In Quebec, the advisory body created by the government is called the *"Comité permanent de lutte à la toxicomanie"* [standing committee on the fight against drug addiction]. The expression "drug addiction" is found everywhere: in legislation, in information documents, and in everyday language. However, since 1963, the WHO has recommended that we abandon this expression because it is imprecise and refer instead to states of physical and psychic dependence, defined as follows:

> *Psychic dependence is a "condition in which a drug produces a feeling of satisfaction and a psychic drive that requires periodic or continuous administration of the drug to produce pleasure or to avoid discomfort. Physical dependence is an "adaptive state that manifests itself by intense physical disturbance when the administration of the drug is suspended or its action is opposed by a specific antagonist. These*

[69] INSERM, (2001) *op. cit.*, pages 206-207.

[70] Caballero, F. and Y. Bisiou (2000) *Droit de la drogue.* Paris, Dalloz, 2nd edition, page 3.

disturbances, that is the abstinence or withdrawal symptoms, consist of physical and psychic symptoms and signs that are characteristic for each drug. [71] [translation]

Furthermore, with the extension of the notion of drugs to other substances (pharmaceutical products, tobacco, alcohol), and with the extension of international control of substances to psychotropic drugs, in 1969 the WHO created a new definition for the term drug dependence that, though its application was initially limited to medication only, has come to be more widely accepted over time:

Drug dependence. A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug. [72]

But it is even more interesting for our purposes to quote even older definitions from the WHO dealing with habituation and addiction:

Drug habituation (habit) is a condition resulting from the repeated consumption of a drug. Its characteristics include:

1. *A desire (but not a compulsion) to continue taking the drug for the sense of improved well-being which it engenders;*
2. *Little or no tendency to increase the dose;*
3. *Some degree of psychic dependence on the effect of the drug, but absence of physical dependence and hence of an abstinence syndrome;*
4. *Detrimental effects, if any, primarily on the individual.*

Drug addiction is a state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include:

1. *An overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means;*
2. *A tendency to increase the dose;*
3. *A psychic (psychological) and generally a physical dependence on the effects of the drug;*
4. *Detrimental effect on the individual and on society.* [73]

This definition is important because, more than the previous two, it allows us to better distinguish between drugs that create primarily a habit and those that create an addiction, that is, the overwhelming need to use them. Now, as we will see in this

---

[71] WHO (1964) *Expert Committee on Addiction-Producing Drugs*, Technical Report Series, no. 273, quoted in Caballero and Bisiou, *op. cit.*, page 5-6.

[72] WHO (1969) *Expert Committee on Drug Dependence*, Technical Report Series, no. 407, quoted in Caballero and Bisiou, (2000), *op. cit.*, page 6.

[73] WHO (1952) *Expert Committee on Drugs Liable to Produce Addiction*, Technical Report Series, no 57, quoted in Caballero and Bisiou (2000), *op. cit.*, page 4-5.

chapter, cannabis corresponds much more to the criteria of a substance likely to create some degree of habituation and not an addiction.

In addition to drug addiction, thinking about drugs means also thinking about illicit substances. Now, as a wide range of works and an increasing number of practices have established, for practical purposes, the actual distinction is made on the combined levels of the substance's toxicity (its dangers) and the uses (use, abuse, heavy use) that characterize it, not on the level of its legal and symbolic status.

Cannabis dependence

Let us first establish that animal studies on dependence and withdrawal are not very pertinent since most of them use doses that have nothing in common with the doses used by humans, even chronic users. Moreover, we note that studies on naïve animals (no experience with other drugs) have not been able to establish self-administering behaviour and that is the only technique that allows for the direct assessment of the reinforcing properties of a molecule. One of the probable explanations stems from the long plasma half-life of Δ^9THC, which we know is eliminated slowly by an organism (up to 25 days as we saw in the Chapter 5).[74] We also note that even after administration of very high doses of Δ^9THC, somatic signs of spontaneous withdrawal were not observed in rodents, pigeons, dogs or monkeys.[75] Lastly, we note that all in all, we know little about the biophysiological and psychological mechanisms of dependence.

The idea of cannabis dependence has been the subject of criticism due to its overly medical aspect (having little regard for the differences in social context of the ways and situations in which it is used) and circular reasoning (for example, the fact that drugs are illegal means that their use is necessarily illegal, yet this is one of the criteria for dependence).[76] Nevertheless, when measured in accordance with the criteria of the DSM, a cannabis dependence syndrome presents no differences from an alcohol or heroin dependence syndrome. Furthermore, establishing the relative dangers of cannabis is not contrary to the objectives of public health.

The nosologic criteria of the DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*) of the *American Psychiatric Association* undoubtedly remain the most widely used in studies on dependence, especially since the majority of drug research is conducted in the United States and Commonwealth countries (England, Australia, Canada…) that use this instrument.

---

[74] INSERM, (2001), *op. cit.*, pages 274-275.

[75] *Ibid.*, page 270.

[76] Cohen, P. testimony before the Senate Committee; also Alexander B.K., professor, Department of Psychology, University Simon Fraser, testimony before the Senate Committee on Illegal Drugs, Senate of Canada, First Session of the Thirty-Seventh Parliament, April 23, 2001, Issue 1.

The DSM-IV distinguishes between criteria for substance abuse and criteria for dependence. We have reprinted them here in accordance with the INSERM report.

Diagnostic Criteria for Substance Abuse according to the DSM-IV

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home;
2. Recurrent substance use in situations in which it is physically hazardous;
3. Recurrent substance-related legal problems;
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Diagnostic Criteria for Substance Dependence according to the DSM-IV

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:
1. Tolerance, as defined by either of the following:
a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect;
b. Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
a. The characteristic withdrawal syndrome for the substance;
b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended;
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use;
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects;
6. Important social, occupational, or recreational activities are given up or reduced because of substance use;
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

The existence of a cannabis dependence syndrome in humans can be inferred using various methods: epidemiological investigations and clinical studies (which usually use DSM criteria), and requests for treatment.

Epidemiological investigations

Some epidemiological studies show that cannabis use can lead to psychological dependence. In some cases, they estimate that half of chronic users would develop this kind of dependence.[77] People who use cannabis on a daily basis for several months would be at greater risk of becoming dependent.[78] Interpretation and intercomparison of the various studies is difficult because the denominator is not always common, or even specified (in some cases, it is the general population while in others it is cannabis users and in the latter case, there is not always a distinction among life-long, recent and regular users). The authors also do not always specify if the dependence is recent or life-long.

In the United States, several investigations were conducted into the frequency of use of various psychoactive substances and dependence. Through the *Epidemiological Catchment Area* study, close to 20 000 people were interviewed in five years during the 1980s. The prevalence (in the general population) of cannabis dependence was 4.4%.[79] The *National Comorbidity Survey*, an investigation to estimate the comorbidity between substance abuse and other mental disorders, undertaken between 1990 and 1992 and involving more than 8,000 subjects from the general population between the ages of 15 and 55, also estimated the prevalence of dependence. For the purposes of the investigation, DSM criteria were used and dependence was observed when respondents presented at least three of the nine criteria. According to this study, 4.2% of the 15-54 year olds presented cannabis dependence (14% were dependent on alcohol and 24% on tobacco). Of those who had used cannabis at least once during their life (46%), 9% were considered dependent, compared to 32% for tobacco and 15% for alcohol. Cannabis dependence was more common in men than women (12% versus 5.5% of users), and in those 15-24 than in the others (15% versus 8%).[80] Combining the results of three large investigations into the use of psychoactive substances conducted on households (nearly 88,000 respondents aged 12 and up) Kandel et al.[81] observed that 8% of those who had used cannabis in the previous year (0.7% of the sample) were considered dependent.

---

77 WHO (1997) *op. cit.*.

78 Channabasavanna, M, et al., (1999) "Mental and behavioural disorders due to cannabis use", in Kalant H. et al. (eds.), *The Health Effects of Cannabis*, Toronto: CAMH.

79 Anthony J.C. and J.E. Helzer (1991) "Syndromes of drug abuse and dependence", in Robins L.N. and D.A. Regier (eds.), *Psychiatric Disorders in America*, New York, Free Press, pages: 116-154.

80 Anthony, J.C . et al., (1994) "Comparative epidemiology of dependence on tobacco, alcohol, controlled substances and inhalants: basic findings from the National Comorbidity Survey." *Experimental and Clinical Psychopharmacology*, 2: 244-268.

81 Kandel, D. et al. (1997) "Prevalence and demographic correlates of symptoms of last year dependence on alcohol, nicotine, marijuana and cocaine in the US population." *Drugs, Alcohol and Dependency*, 44: 11-29. See also Kandel D. and M. Davies, (1992) "Progression to regular marijuana involvement: Phenomenology and risk factors for near daily use", in M. Glantz and R. Pickens (eds.), *Vulnerability to Drug Abuse*, 211-253, Washington DC, American Psychological Association.

In New Zealand, a longitudinal study involving a cohort of 1,265 children born in 1977 in an urban setting and followed since birth revealed that at age 21, not less than 70% had used cannabis. Of those, 13% had had a problem with dependence measured in accordance with the DSM-IV during their lifetime.[82] Another New Zealand study involving a cohort of 1,000 people found similar results: at age 21, 62% had used cannabis and at age 26, 70% had. The prevalence of dependence using DSM III-R criteria went from 3.6% at age 18 to 9.6% at age 21 (or nearly 15% of users).[83]

In Australia, an investigation involving more than 10,000 people from the general population who were over 18 years of age showed that approximately 1.5% of users during the previous year and 20% of current users showed signs of dependence based on the DSM-IV.[84]

In the Netherlands, a study involving a sample of the national population aged 18 to 65 (7,000 subjects) showed that 10% of users had had signs of dependence during their lifetime.[85]

Clinical studies

It is difficult to generalize based on the results of clinical studies, but it is interesting to see to what extent their results are similar to those of epidemiologic studies. Kosten examined the validity of DSM-III R criteria to identify syndromes of dependence on various psychoactive substances including cannabis. He observed that the criteria for syndromes of alcohol, cocaine and opioid dependence were strongly consistent. The results were more ambiguous for cannabis. A criterion-referenced analysis revealed that there were three dimensions to the cannabis dependence syndrome: (1) compulsion – indicated by a change in social activities attributable to the drug; (2) difficulty stopping – revealed by the inability to reduce use, a return to previous levels after stopping temporarily and a degree of tolerance of the effects; and (3) withdrawal signs – revealed by their disappearance with re-use and continuing use despite recognized difficulties.[86]

Studies on long-term users

In Canada, Hathaway conducted a study between October 2000 and April 2001 to identify problem use and dependence in long-term users based on the DSM-IV criteria.[87] The sample was made of 104 individuals (64 men and 40 women) aged 18 to

---

82 Fergusson, D.M. and L.J. Horwood (2000) "Cannabis use and dependence in a New Zealand birth cohort." *New Zealand Medical Journal*, 113: 156-158

83 Poulton, R., et al., (2001) "Persistence and perceived consequences of cannabis use and dependence among young adults: implications for policy." *New Zealand Medical Journal*, 114: 13-16.

84 Swift, W. et al., (2001) "Cannabis use and dependence among Australian adults: results from the National Survey of Mental Health and Well-being." *Addiction*, 96: 737-748.

85 Van Laar, M., et al., (2001) *National Drug Monitor. Jaarbericht 2001.* Utrecht: NDM Bureau.

86 T.R. Kosten et al., Substance-use disorders in DSM-III-R, *British Journal of Psychiatry*, 151, 8-19, 1987.

87 Hathaway, A.D. (2001) "Cannabis effects and dependency concerns in long-term frequent users: a missing piece of the public health puzzle." Transmitted to the Senate Committee on Illegal Drugs

55 (mean age 34). 80% had used cannabis on a weekly basis, 51% on a daily basis during the preceding 12 months, and close to half (49%) had used one ounce (28 grams) or more per month. Reasons to use included: to relax (89%), to feel good (81%), to enjoy music or films (72%), because they are bored (64%) or as a source of inspiration (60%).

Respondents were asked if they had ever engaged in deviant activity related to cannabis use. The most frequent answer was to have been in an uncomfortable situation in order to get cannabis. Other activities included borrowing money, selling cannabis to support their own drug use, and taking on extra work to buy cannabis. Only 6% ever had recurring legal problems due to their use of cannabis. With respect to dependence, 30% reported a lifetime prevalence of three or more of the criteria, 15% during the 12 months prior to the interview.

> *In light of this finding, the most frequently encountered problems with cannabis have more to do with self-perceptions of excessive use levels than with the drug's perceived impact on health, social obligations and relationships, or other activities. Lending support to the highly subjective nature of his evaluative process, no significant correlations were found between amounts nor frequency of use and the number of reported DSM-IC items. For those whom cannabis dependency problems progress to the point of seeking out or considering formal help, however, the substantive significance of perceived excessive use levels cannot be overlooked.* [88]

The comparative study by Cohen and Kaal presented in the previous chapter also included data on dependency symptoms. Between 21% and 24% of the subjects presented 3 or more DSM-IV criteria in their lifetime as the following table shows.

Number of positive DSM IV answers
Amsterdam, San Francisco, Bremen [89]

	Ever experienced				Last twelve months			
Number of criteria	Amsterdam		San Francisco		San Francisco		Bremen	
	N	%	N	%	N	%	N	%
0	85	39	129	49	233	88	43	78
1	37	17	53	20	17	6	5	9
2	43	20	30	11	9	3	4	7
3	19	9	28	11	3	1	2	4
4	15	7	15	6	3	1	1	2
5	9	4	7	3				
6	8	4	3	1				

during the testimony of Professor Hathaway before the Senate Special Committee on Illegal Drugs, Senate of Canada, First session of the thirty-seventh Parliament, May 14, 2001, Issue 2.

[88] *Ibid.*, page 15.

[89] Cohen, P.D.A. et H.L. Kaal, (2001) *The irrelevance of drug policy. Patterns and careers of experienced cannabis use in the population of Amsterdam, San Francisco and Bremen.* Amsterdam: University of Amsterdam, CEDRO, page 99.

Total	216	100	265	100	265	100	55	100
Average incl. 0	1,5		1,2		0,2		0,4	
Average excl. 0	2,5		2,3		1,8		1,9	

The authors observe a significant correlation between amount of cannabis use (in grams) during top period of use and the number of DSM-IV items ever experienced. However, no correlation was found between the amount of cannabis use during top period of use and number of criteria experiences in the last twelve months.

Requests for treatment

Lastly, we can examine dependence indirectly through requests for treatment. Obviously, this is a very indirect and definitely very imperfect means for several reasons. The very great majority of cannabis users use it irregularly and stop when they reach their twenties. Of those who continue and become regular users, we have just seen that between 10% and 20% will present the criteria for dependence. Most users do not think they need help, which their ability to stop without outside assistance would confirm. Lastly, those who ask for help could be influenced simultaneously by the availability of services as well as the interaction of other problem substances, alcohol, medication or other drugs, or other mental disorders. In fact, it seems that in a significant proportion of cases, requests for treatment related to cannabis come from people with multiple disorders.

Nevertheless, we have heard testimony to the effect that requests for treatment for problems with cannabis dependence are on the rise and that this increase could be related to the THC content.

In Europe, requests for treatment where the main problem is cannabis-related vary widely from country to country, ranging from 6% in Spain (one of the countries where use is most widespread and most tolerated) to 25% in Belgium. Sweden, which however has a relatively low rate of use, is at 14%, comparable to France (16%) which, however, has a much higher rate of use. In the United States, demand is just as variable depending on the state, from 5% to 30%.[90]

Severity of dependence

Severity of dependence has been evaluated in different ways. In the United States, a study examined approximately 1,100 subjects who had used cannabis more than six times and evaluated the severity of their dependence based on DSM-IV criteria. The level of dependence (low, intermediate or high) corresponded to the number of criteria met.[91] The following results were obtained:

Severity of cannabis dependence based on use[92]

	Distribution of subjects based on type of use											
	Low			Intermediate			Heavy			Total		
Dependence (number of criteria)	T	A	C	T	A	C	T	A	C	T	A	C
Nil (0-2)	18	88	85	14	45	53	5	8	35	13	47	59
Low (3-4)	28	8	11	30	22	21	22	12	34	27	14	18
Moderate (5-6)	34	3	2	39	15	14	51	19	23	40	12	13
Severe (7-9)	19	1	3	17	17	12	23	61	17	20	27	10

T = tobacco; A = alcohol; C = cannabis

We see a consistent situation in which the link between heavy use and dependence is lower for cannabis than for tobacco and alcohol, and in which, over all, dependence on cannabis is the lowest of the three substances.

For his part, professor Roques proposes three classes of products based on their dangers. The first includes heroin, cocaine and alcohol; the second psychostimulants, hallucinogens, tobacco and benzodiazepines; and cannabis is set apart in a separate class. He classifies the dangerousness of drugs using a diverse set of criteria. We have reprinted his table of the dangerousness of drugs on the following page.

---

[90] Rigter, H. and M. van Laar (2002) "Epidemiological aspects of cannabis use." in Pelc I., (ed.) *International Scientific Conference on Cannabis*. Brussels.

[91] Woody G.E. et al., (1993) "Severity of dependence: Data from the DSM-IV field trials" *Addiction* 88, 1573-1579.

[92] Reprinted from INSERM (2001) *op. cit.*, page 73.

Danger Factors of "drugs" (reprinted from Roques, B. (1999), page: 296

	Heroin	Cocaine	MDNA	Psycho-stimulants	Alcohol	Benzo-diazepines	Cannabi-noids	Tobacco
Dopamine Overactivation	+++	++++	+++	++++	+	±	+	+
Hypersensi-tivity to Dopamine	++	+++	?	+++	±	?	±	?
Activation of Opioid System	++++	++	?	+	++	+	±	±
Physical Dependence	very high	low	very low	low	very high	average	low	high
Psychic Dependence	very high	high but intermittent	?	average	very high	high	low	very high
Neurotoxicity	low	high	very high (?)	high	high	0	0	0
General Toxicity	high	high	possibly very high	high	high	very low	very low	very high (cancer)
Danger to Society	very high	very high	low (?)	low (exceptions)	high	low	low	0
Replacement Therapy	yes	yes	no	no	yes	not researched	not researched	yes

In closing, we note that there is no known physical dependence on cannabis, even though in the most severe cases, withdrawal is sometimes accompanied by physical signs such as trembling, insomnia, irritability, etc.

Tolerance

From a technical standpoint, tolerance is defined as follows:

> *the property of the human organism to endure the administration of usually effective doses of a given substance without displaying a reaction. With respect to drugs, this tolerance can lead to increased doses in order to achieve the desired effect.*[93] [translation]

Development of tolerance is associated with pharmacodynamic changes. In some animal studies, chronic administration of THC reduced the density of receptors in some regions of the brain[94] and increased it in others; these effects were reversible.[95]

In man as in animals, studies have observed the phenomenon of cannabis tolerance. However, the data must be interpreted with care insofar as some studies and clinical cases have also found that regular users needed less cannabis to achieve the desired effect.[96] Nevertheless, a study by Wiesbeck et al. involving 5,611 subjects reported that 16% of frequent cannabis users had a history of a withdrawal syndrome.[97]

It is tolerance of a substance that leads to withdrawal symptoms. In recent years, clinical data has been accumulated on withdrawal symptoms in heavy cannabis users (several doses per day in an ongoing manner for several years). The symptoms observed include agitation, loss of appetite, nausea, disturbed sleep, irritability or hyperactivity and an increased body temperature.[98] These symptoms appeared after 24 hours of abstinence, peaked after two to four days and diminished within seven days. The symptoms were markedly less severe and of shorter duration than with other psychoactive substances. Furthermore, clinical studies showed that most subjects continued to perform their daily activities in a normal fashion.

---

93 OMS (1969), in Caballero et Bisiou (2000), *op. cit.*, page 6.

94 Rodriguez de Fonseca, F. et al., (1994) "Downregulation of rat brain cannabinol binding sites after chronic delta-9-THC treatment", *Pharm. Biochem. Behav.* 47, 33-40.

95 Westlake, T.M. et al., (1996) "Chronic exposure to delta-9-THC fails to irreversibly alter brain cannabinoid receptors" *Brain Research*, 544, 145-149.

96 Beardsley, R.M et al., (1986) "Dependence on THC in rhesus monkeys", *Journal Pharmacol. Exp. Ther.*. 239 (2), 311-319.

97 Wiesbeck, G.A., et al., (1996) "An evaluation of the history of a marijuana withdrawal syndrome in a large population." *Addiction*, 91 (10): 1573-1579.

98 Kouri, E.M. et al., (2000) "Abstinence symptoms during withdrawal from chronic marijuana use." *Experimental and Clinical Psychopharmacology*, 8: 483-[illegible]2.

To summarize

In Chapter 6, we have seen that use does not follow a single pattern, even less so a pattern inevitably leading to increased use. Even in chronic users, the use of cannabis is sometimes irregular and involves periods of abstinence and of more intensive use. We have also seen that current epidemiological studies are not sensitive enough to the complex interactions between the multiple factors that influence patterns of use. These various difficulties make it more difficult to estimate the number of problem users, even more so the number of persons who may become dependent.

In our view, it is clear that the term addiction, severely criticized for its medical and moral overtones, is inadequate to properly describe the different forms of at-risk and problem uses. It is even less useful when it comes to cannabis, whose addictive potential is low. It is therefore of lmited use to inform public policies aiming to prevent at-risk and problem use and to assist excessive users. Further, we are of the view that dependency is but one of the many consequences of excessive use of cannabis and that this possibility must not be overestimated.

For these reasons, we propose to distinguish between different uses on the basis of four criteria: context, quantity, frequency, and duration and intensity.

Proposed Criteria for Differentiating Use Types

	Environment	Quantity	Frequency	Period of use and intensity
Experimental / Occasional	Curiosity	Variable	A few times over lifetime	None
Regular	Recreational, social Mainly in evening Mainly in a group	A few joints Less than one gram per month	A few times per month	Spread over several years but rarely intensive
At-risk	Recreational and occupational (to go to school, to go to work, for sport…) Alone, in the morning Under 16 years of age	Between 0.1 and 1 gram per day	A few times per week, evenings, especially weekends	Spread over several years with high intensity periods
Excessive	Occupational and personal problems No self regulation of use	Over one gram per day	More than once per day	Spread over several years with several months at a time of high intensity use

Given the poor knowledge base on use patterns in Canada, we have no choice but to speculate on the number of persons falling in each of these types of uses. We propose the following broad parameters:

- In adults: we have estimated that approximately 100,000 persons over 18 would use cannabis daily.
  - If 30% to 40% use between 0.1 to 1 gram per day, this means that 30,000 to 40,000 may be at-risk;
  - If 5% to 10% use more than 1 gram per day, this means that 5,000 to 10,000 adults have excessive use patterns.
- In youth 12 to 17, we have estimated that as many as 225,000 use cannabis daily.
  - If it is agreed that any use below the age of 16 is excessive use, and that youths 12-15 who use cannabis may represent approximately 25% of this group, then about 50,000 may uses excessively;
  - Of the remaining 175,000, if 30% to 40% use 0,1 to 1 gram per day, approximately 50,000 to 70,000 would be at-risk;
  - If 5% to 10% of the remaining 175,000 use more than 1 gram per day, then approximately 8,000 to 17,000 use excessively.

We are aware that these estimates do not account other variables, such as context and duration of use. We can only hope that future epidemiological studies, which must be undertaken regularly, will help further explain the complexity and variability of these uses.

CONCLUSIONS

In total, based on all the data from the research and the testimony heard regarding the effects and consequences of cannabis use, **the Committee concludes that the state of knowledge supports the belief that, for the vast majority of recreational users, cannabis use presents no harmful consequences for physical, psychological or social well-being in either the short or the long term.**

More specifically, this conclusion is based on the following conclusions.

Conclusions of Chapter 7	
Acute effects of cannabis	➢ The immediate effects of cannabis are characterized by feelings of euphoria, relaxation and sociability; they are accompanied by impairment of short-term memory, concentration and some psychomotor skills.
Distinctions between uses	➢ For purposes of public policy, the Committee does not feel that the traditional distinctions between acute and chronic effects are useful. ➢ Similarly, the Committee does not feel the dichotomy of use and dependence is useful. ➢ The research data does not allow for a clear distinction between use, at-risk use and heavy use. ➢ The amount consumed is an indicator, but other factors, psychosocial factors and factors relating to the context of use and the quality of the substance, are equally determining in the passage from use to at-risk use and heavy use.
At-risk use and heavy use in adults	➢ Nevertheless, the Committee feels that for people over the age of 16, at-risk use lies within the range of 0.1 to 1 gram per day; anything more than that is heavy use, which can have negative consequences on the physical, psychological and social well-being of the user. ➢ According to this distinction, and in accordance with the epidemiological data available, there is reason to believe that approximately 100,000 Canadians could be at-risk users and approximately 80,000 could be heavy users.
Any use in those under age 16 is high-risk use	➢ The Committee feels that, because of its potential effects on the endogenous cannabinoid system and cognitive and psychosocial functions, any use in those under age 16 is at-risk use; ➢ Our estimation would suggest that approximately 50,000 youths fall in this category. ➢ For those between the ages of 16 and 18, heavy use is not necessarily daily use but use in the morning, alone or during school activities;
Consequences of heavy use	➢ Heavy use of smoked cannabis can have certain negative consequences for physical health, in particular for the respiratory system (chronic bronchitis, cancer of the upper respiratory tract). ➢ Heavy use of cannabis can result in negative psychological consequences for users, in particular impaired concentration and learning and, in rare cases and with people already predisposed, psychotic and schizophrenic episodes.

	➢ **Heavy use of cannabis can result in consequences for a user's social well-being, in particular their occupational and social situation and their ability to perform tasks.** ➢ **Heavy use of cannabis can result in dependence requiring treatment; however, dependence caused by cannabis is less severe and less frequent that dependence on other psychotropic substances, including alcohol and tobacco.**

CHAPTER 8

DRIVING UNDER THE INFLUENCE OF CANNABIS[1]

Stan Thompson was 18 when he and four other teenagers from Kanata were killed in a horrific car accident near Perth that summer day. A youth was found responsible for the fatal accident and served eight months of a 12-month sentence. Cannabis and alcohol-impaired driving was the cause. … The year following Stan's death, his father, Greg Thompson, went to local high schools to talk about the tragedy. He spoke to students about what went wrong and how the tragedy could have been prevented. … His message was that driving a vehicle and smoking marijuana does and will affect driving abilities. He pleaded with the kids not to do it. … Cannabis is not a benign substance. There is very little in the way of research that allows anyone to determine levels of impairment related to cannabis and driving ability, much less the levels of impairment related to cannabis and alcohol and driving ability. We have seen in the Manitoba survey, over one-half of the kids that are using cannabis do so in cars and during school hours. There is no technical or scientific ability to test for cannabis impairment. We do not have the technology, scientific data or the research. We do not have the proper legislation. Studies done in British Columbia indicate that 12 per cent to 14 per cent of the drivers involved fatal motor vehicle accidents had cannabis in their systems. The Government of Quebec and the insurance board in Quebec are presently doing road surveys where people are voluntarily submitting to urine or blood tests. The findings in these tests are that between 12 per cent and 14 per cent of those drivers has cannabis in their system while driving. [2]

If there is one issue, other than the effects of cannabis use on young people or the effects of substance abuse, that is likely to be of concern to society and governments, then it is certainly the issue of how it affects the ability to drive a vehicle. We are already familiar with the effects of alcohol on driving, and the many accidents involving injuries or deaths to young people. In spite of the decreases in use noted in recent years, it is not difficult to admit that one fatal accident caused by the use of a substance is already one accident too many.

---

1 In addition to the specific studies we consulted, which will be referred to appropriately, this chapter is largely based on the surveys carried out by INSERM (2001) *op. cit.*, Ramaekers et al., for the International Science Conference on Cannabis in Pelc, I., *op. cit.*), and Smiley (1999) in Kalant (ed.) *op.cit.*

2 R.G. Lesser, Chief Superintendent, Royal Canadian Mounted Police, testifying before the Special Senate Committee on Illegal Drugs, October 29, 2001, Issue 8, page 17.

As it happens, after alcohol, cannabis is the most widely used psychoactive substance, particularly among young people in the 16-25 age group. Casual use occurs most often in a festive setting, at weekend parties, often also accompanied by alcohol. People in this age group are also the most likely to have a car accident and are also susceptible to having an accident while impaired.

We have seen that cannabis affects psychomotor skills for up to five hours after use. The psychoactive effects of cannabis are also dependent on the amount used, the concentration of THC and the morphology, experience and expectations of users. But what are the specific effects of cannabis on the ability to drive motor vehicles? What are the effects of alcohol and cannabis combined? And what tools are available to detect the presence of a concentration of THC that is likely to significantly affect the psychomotor skills involved in vehicle operation?

Here again, the witnesses heard by the Committee vary in their interpretation of the study results. Thus, the Canadian Police Association told us:

> *Driving while intoxicated by drugs impairs judgment and motor coordination. In one study involving aircraft 10 licensed pilots were given one marijuana joint containing 19 milligrams of THC - a relatively small amount. Twenty-four hours after smoking the joint, they were tested in a flight simulator. All 10 of the pilots made errors in landing and one missed the runway completely.*[3]

Two weeks later, Dr. John Morgan of the City University of New York Medical School said in reference to the same study:

> *A California-based scientist named Jerome Yesavage wrote the study. It was done in the early 1980s, I think, and it attracted enormous attention. ... Doctor Yesavage's study ... was completely uncontrolled. ... As you all have heard, it is difficult to control for marijuana use. When Doctor Yesavage was funded by the federal government to repeat the study with the simple controls that others and I had suggested, they were unable to show any impact of marijuana use after four hours in a similar group of people. Therefore, I believe that the truth is that marijuana use will impact airplane and driving simulators and to some degree driving performance for three hours to four hours after use; however there is no sustained impact. Any impact is relatively minor.*[4]

Making reference to Robbe's work, which we will be examining in greater detail in this chapter, Professor Morgan added:

> *A Dutch scientist who has for years worked on driving experiments found that marijuana using drivers have a little difficulty staying right in the middle of the road. That is most sensitive test. If you smoke marijuana, you tend to weave a little bit more than completely sober people do. That is important,*

---

[3] Dale Orban, Detective Sergeant, Regina Police Service, for the Canadian Police Association, testimony given before the Special Senate Committee on Illegal Drugs, May 28, 2001, Issue 3, page 47.

[4] Dr John Morgan, Professor at the City University of New York Medical School, testimony before the Special Senate Committee on Illegal Drugs, June 11, 2001, Issue 4, page 40-41.

> *although there have been no studies to show that that amount of weaving had a gross impact on driving ability.*
> *The Dutch scientist included in his report that the amount of weaving was approximately the same in individuals consuming very small amounts of alcohol, very small doses of bensodiazopenes and very small doses of antihistamines.* [5]

On the same day, Professor Kalant of the University of Toronto responded as follows:

> *Dr. Morgan referred to some experimental studies this morning. A number of studies, reviewed by Dr. Smiley in the report of the World Health Organization Committee on Health Effects of Cannabis, indicate a fair measure of agreement on what the predominant effects on driving are. The lane control, as Dr. Morgan mentioned, is impaired. The person does not steer as accurately. In addition, there was slower starting time and slower braking time. There was decreased visual search. In other words, when you drive, you must monitor for sources of danger to both sides and not just ahead of you. There was decreased monitoring, decreased recognition of danger signals. The effects were synergistic with those of alcohol. The one favourable thing about cannabis compared with alcohol was that there was less aggressiveness in the cannabis smokers than in the drinkers, so they were less likely to pass dangerously or to speed. Nevertheless, driving ability was impaired not just by weaker, poorer steering control, but also by less alertness to unexpected things that might happen and pose a hazard.*
> *I will not go into the statistics of actual field studies of the involvement of cannabis in driving accidents. However, I would like to say that a number of studies have shown that there has been evidence of cannabis presence in the blood or the urine of people who have been stopped for impaired driving who did not have alcohol present.* [6]

As we can see, and as was the case with respect to the effects and consequences on the health of users, there are divergent opinions about the interpretation of studies and their meaning in connection with the specific effects of marijuana on driving.

This chapter is divided into three sections. The first considers the ways of testing for the presence of cannabinoids in the body. The second analyses studies on the known prevalence of impaired driving, in both accident and non-accident contexts. The third and last summarizes what is known about the effects of cannabis on driving based on both laboratory and field studies. As in the other chapters, the Committee will then draw its own conclusions.

---

5 *Ibid.*

6 Dr Harold Kalant, Professor Emeritus, University of Toronto, testimony before the Special Senate Committee on Illegal Drugs, June 11, 2001, Issue 4, page 75.

FORMS OF TESTING

There are five known media for testing the presence of cannabinoids in the organism: blood, urine, saliva, hair and perspiration.

Blood is the most appropriate medium for detecting recent cannabis use because only a blood analysis can distinguish between the active ingredients of cannabis and metabolites that have no psychoactive effects. However, as we have already seen, blood concentrations of Δ^9THC peak 9 minutes after smoking; after 10 minutes only two-thirds of the concentration remains, and it is down to 5 to 10% at the end of an hour; after two hours, it becomes difficult to detect. Thus not all methods are appropriate for testing because of the strong possibility of obtaining false negatives and false positives. The most reliable method, gas chromatography using mass spectrometry for detection, is extremely sensitive and can also estimate the time that has elapsed between the most recent use and the taking of the blood sample.

We saw in Chapter 7 that there was a dose-response relationship: 25 puffs affect cognition more than do 10 puffs, and 10 have more of an effect than 4. But not much data is available on the relationship between concentration and effects on people, and the ability to answer the key road safety question, namely at what concentration can one consider that faculties are impaired? In France, the Δ^9THC level that constitutes testing positive has been set at 1ng/ml[7] for drivers involved in fatal accidents. Another author has come up with a formula that establishes a relationship between Δ^9THC, 11-OH Δ^9THC and Δ^9THC-COOH to determine a cannabis influence factor with a positive threshold of 10ng/ml. An equal concentration of Δ^9THC and COOH suggest use approximately 30 minutes beforehand, and hence a very high probability of psychoactive effects, whereas a higher concentration of COOH than Δ^9THC suggests that use was more than 40 minutes beforehand. However, a concentration of COOH in excess of 40 μg/l would indicate a chronic user, and hence it becomes impossible to determine when the last use occurred. Other research has established that a blood concentration of 10 to 15 ng/ml suggests recent use, without however being able to give an exact figure.[8]

Urine tests are also frequently employed and remain the most appropriate method for rapidly determining whether subjects have been using. On the other hand, traces of cannabis can remain in urine for weeks. Furthermore, the traces that remain are of Δ^9THC-COOH, an inactive metabolite. Consequently, urinalyses are primarily useful for epidemiological measurements of cannabis use, and cannot contribute to information about impaired driving.

---

[7] In this chapter, ng means nanogram (i.e. one billion of one gram) and μg means microgram (one million of one gram)

[8] INSERM (2001), *op. cit.*, pages 152-153.

The levels of concentration of Δ^9THC-COOH in urine are very high: for someone who smokes a joint a day, the level is between 50 to 500 ng/ml and may reach several thousands ng/ml in heavy users; the currently recommended threshold level for testing positive is 50ng/ml urine.

Saliva is a very promising option for road safety because it is non intrusive and can indicate recent use with some accuracy. The presence of Δ^9THC in saliva essentially results from the phenomenon of bucco-dental sequestration during inhalation. Concentrations are very high in the few minutes following absorption, varying between 50 and 1,000 ng/ml, but then decline very quickly in the hours that follow, though they remain detectable for an average of four to six hours. The European ROSITA project compared the reliability of samples taken from urine, perspiration and saliva compared to that taken from blood. Saliva is by far the most reliable, showing an exact correlation in 91% of cases. However, the low level of concentration during the period when the psychoactive effects are active means that sensitive analytical methods are essential. There is unfortunately not yet a sufficiently accurate and reliable rapid detection tool that can be used in driving situations. Hence the driving detection tools correctly identified only 18 to 25% of cases and led to many false negatives.[9]

Perspiration is generally considered poor for detection purposes, because of the persistence of Δ^9THC in sweat, and the fact that it is also excreted into sweat in small quantities.

Hair looks very promising because the significant amount of Δ^9THC can determine time since and level of use (low, moderate, high). However, concentrations are only a few ng per mg of hair, which requires highly efficient testing.

The following table, taken from the INSERM report, summarizes the main characteristics of the various biological testing media; where available, we have added the threshold detection level adopted.

---

[9] Ramaekers, J.G. et al., 2002 "Performance impairment and risk of motor vehicle crashes after cannabis use" in Pelc, I. (ed.) *International Scientific Conference on Cannabis*, Brussels, page 81.

Main Characteristics of Biological Testing Media

	Primary cannabinoids	Maximum detection period	Useful for	Methodologies available	Threshold for positive test
Urine	THC-COOH (inactive)	Occasional use: 2 to 7 days Regular use: 7 to 21 days	Identifies use	Yes, many rapid tests	50ng of Δ^9THC-COOH per ml
Saliva	THC (active)	2 to 10 hours	Identifies recent use	No, no rapid tests	not determined
Perspiration	THC	Highly variable	Not useful	No, no rapid tests	not useful
Hair	THC	Infinite	Identifying & monitoring regular user	Yes, CPG-SM	not determined
Blood	THC 11-OH THC THC-COOH	2 to 10 hours	Confirmation, identification, dosage	Yes, CPG-SM	1ng/ml (France)

In all instances, the handling and transportation of samples and the toxicological dosages are essential to the quality of the analyses.

There is still considerable uncertainty about thresholds that make it possible to affirm that the presence of Δ^9THC would impair the driver. Furthermore, there is still no reliable rapid screening test to identify recent use (urine tests cannot do this). Moreover, other drugs besides alcohol, including many types of prescription medicines, may have an impact on driving. That is why many authors, and a number of witnesses, suggested to us that Canada adopt the Drug Evaluation and Classification Program (DEC) and recognize police officers trained as Drug Recognition Experts. This practice has now been adopted in most U.S. states (at least 34, as well as the District of Columbia), British Columbia, Australia, Norway and Sweden.

The typical scenario for driving under the influence of psychoactive substances other than alcohol is as follows: a vehicle attracts the attention of a police officer, who pulls the vehicle over and questions the driver; if there are reasonable grounds to believe that the driver is intoxicated, a breathalyser test is administered; however, when the test yields a result below the legal limit, the police officer may still not be convinced that the driver is capable of driving, but how is this to be proven? Before, more often than not, the police officer had to release the driver. As we have just seen, there are no equivalents to the breathalyser test for drugs and medicines, and, for cannabis in particular, traces found in urine in no way establish that use was recent. It was in this context that the police officers working for the Los Angeles Police Department developed the Drug Recognition Expert System (DRE) in the early 1980s. Police

officers are given specific training in the detection of people driving under the influence of psychoactive substances and in the use of the DEC.

The system allows police officers who have reason to believe that drivers are intoxicated to call on an officer specially trained in drug recognition, who can then evaluate the driver on the basis of a set of systematic and rigorous factors that are recognized as signs of the presence of drugs. The process involves 12 steps:

- Breath alcohol test: This test will have been conducted by the police officer who stopped the vehicle. The Drug Recognition Expert is only called in when the test is negative.
- Interview by the arresting officer: The DRE asks the arresting officer a series of conventional questions: in what condition did he or she find the suspect, what he or she had observed, if he or she found drugs in the vehicle, suspect's statement, etc.
- Preliminary examination (the first of three pulse measurements): This involves determining whether there are reasonable grounds to suspect the presence of drugs, and hence eliminate the possibility that there is a medical condition. The DRE observes the suspect's overall condition, and questions the suspect about health, examines the pupils and gaze, and takes the first of three pulse measurements. If the DRE feels that there are no signs, the suspect is released. If the condition is medical, a medical evaluation is requested. However, if drugs are suspected, the examination continues
- Examination of the eyes: This consists of three tests: horizontal gaze, vertical gaze and convergence. Apparently when under the influence of any drug, it is impossible to have an involuntary jerky movement of the pupils on the vertical axis without first provoking such movements on the horizontal axis. Thus if there are only vertical jerky pupil movements, it is likely a medical condition (e.g. brain damage). If there is horizontal jerkiness, there are likely drugs involved. To determine horizontal movements, the DRE moves a pen or other object horizontally in front of the suspect's eyes. For vertical movement, the pen is moved from top to bottom. Furthermore, as certain drugs prevent eyes from being able to converge towards the bridge of the nose, the DRE performs a convergence test by placing the pen or object on the person's nose and asking the suspect to look at it
- Divided attention psychophysical tests: The tests include balancing, walking, standing on one leg and the finger-to-nose test
- Vital signs examination: This is the second of three pulse measurements, as well as a measurement of blood pressure and body temperature
- Dark room examination: This involves examining the pupils under four different lighting conditions: room lighting, darkness, indirect light and direct light
- Examination of muscle tone: arm movements

- Examination for injection sites
- Questions about suspect's drug use and living habits
- Opinion: On the basis of all the evidence, the DRE forms an opinion based on a reasonable amount of certainty
- Toxicological examination: The purpose of this examination is to corroborate the analysis by the DRE officer. The decision concerning prosecution is made only when the analyses are returned.

The system was standardized in the early 1980s with the assistance of the U.S. National Highway Traffic Safety Administration. It was first tested in a laboratory study.[10] In the study, four Drug Recognition Experts evaluated subjects who had received either a placebo or a dose of drugs. Neither the subjects nor the officers knew who had received the drugs. In 95% of cases, the officers correctly identified the subjects who had not been given drugs. In 97% of cases, they correctly identified the subjects who had been given drugs and in 98.7% of cases, they were able to determine which subjects were under the influence of drugs.

A field study was then conducted in 1985, once again with the assistance of the Highway Traffic Safety Administration.[11] In the study, blood samples of 173 drivers arrested for driving under the influence of drugs were analyzed by an independent laboratory. The study showed that the analyses carried out by the Drug Recognition Expert officers correctly predicted the presence of drugs other than alcohol in 94% of cases. In 79% of the cases, the analyses of the officers identifying the presence of a specific drug turned out to be accurate.

The most complete study was carried out in Arizona in 1994. In this study, the files of over 500 persons arrested for driving under the influence of drugs were analyzed, and toxicological analyses were conducted. The study showed that the toxicological analyses corroborated the conclusions of the officers in 83.5% of cases. Similar studies conducted in other states yielded comparable results: 81.3% in Texas, 84.5% in Minnesota, 88.2% in California, 88.2% in Hawaii and 88% in Oregon.

With respect specifically to cannabis, the expected signs listed in the system are generally the following: no horizontal or vertical shaking, but no convergence in gaze, dilated pupils, accelerated pulse and high blood pressure.

In short, given the limits of detection in the field of the influence of cannabis and the results of these studies, **it would appear that it would be highly desirable to adopt the DEC and train police officers in drug recognition.**

---

[10] Bigelow, G.E. (1985) *Identifying types of drug intoxication; laboratory evaluation of a subject procedure.* Cited in Sandler, D. (2000) "Expert and Opinion Testimony of Law Enforcement Officers Regarding Identification of Drug Impaired Drivers." *University of Hawaii Law Review* 23 (1), 150-181.

[11] Compton, P.R. (1986) *Field Evaluation of the Los Angeles Police Department Drugs Detection Procedure.* Cited in Sandler, *op. cit.*, page 151.

EPIDEMIOLOGICAL DATA

According to a number of the witnesses we heard, more than 40% of people whose driving abilities are impaired would drive under the influence of cannabis. Others have said that approximately 12% of accidents causing injury could be attributed to the use of cannabis. What do the studies reveal?

Data on the frequency of driving under the influence of cannabis (whether on its own or together with other substances) are, for obvious reasons, difficult to obtain. First, for drivers involved in an accident, a positive breathalyzer test means most of the time that no other measurements are taken because a blood alcohol level above the legal limit is enough to take legal action. Second, the methods available to detect the presence of THC are intrusive (blood, urine), unlike the breathalyzer, and hence pose specific legal and ethical problems. Other forms of measurements, such as saliva samples, do not, for the time being, allow roadside detection. Lastly, in studies of all drivers, the consent of drivers is required to take a blood or urine sample, thus limiting the possibility of generalizing results. Nevertheless, we will summarize the main points of a number of studies conducted in recent years.

Studies not involving accidents

Two types of studies were conducted: surveys of all drivers selected at random from the flow of traffic at various times of the day and week, and studies where it was presumed that the people were driving under the influence during police checks. The following table, drawn from the various data available from INSERM, summarizes these studies.

Detection and prevalence of cannabis in Europe and Quebec where no accidents are involved[12]

Reference country	Population	Detection method	Sample	Prevalence (%)
No presumption of driving under the influence of psychoactive substances				
Germany, Kruger et al., 1995	All drivers	Screening: FPIA saliva Confirmation: CG/SM saliva	2 234 (of 3 027)	0.6
Netherlands, Mathtijssen, 1998	Night drivers on weekends	Screening: combined saliva, perspiration and urine test	293 (of 402)	5
Italy, Zancanner et al., 1995	Night drivers on weekends	Clinical screening, clinical and toxicological check (blood, urine)	1 237	1.5

[12] Table reproduced from INSERM (2001), *op. cit.*, page 175.

Detection and prevalence of cannabis in Europe and Quebec where no accidents are involved[12]				
Reference country	Population	Detection method	Sample	Prevalence (%)
Canada Dussault et al., 2000	Highway drivers (representative survey)	Urine Saliva Breathalyzer (alcohol)	2 281 2 260 5 281	5 (in progress) > 0.8 : 0.8
With presumption of driving under the influence of psychoactive substances				
Norway, Skurtveit et al., 1996	Drivers	Screening: immunoassay blood; Confirmation: CG/SM	2 529	26
Denmark, Worm and Steentoft, 1996	Drivers	blood Screening: RIA blood Confirmation: CG/SM	317 221	10 17
United Kingdom, Scottland, Seymour and Oliver, 1999	Drivers	blood Screening: immunoassay blood; Confirmation: CG/SM blood	640	26

In all, it was observed that the detection rates for the presence of cannabis varied between 1% and 5% when there was no presumption of impaired driving. However, the missing data, which likely resulted from refusals to supply a sample, made it impossible to draw clear conclusions. The studies with presumption of driving under the influence of drugs had clearly higher results: between 10 and 26%. These results do not necessarily reveal a much higher prevalence of driving under the influence of psychoactive substances, but rather a higher level of vigilance by the police. Indeed, as we shall see immediately, the prevalence of cannabis detection in fatal accidents is no higher in Norway (7.5%) than in other countries.

Studies where an accident was involved

It is difficult to compare studies between countries because the detection methods, even in an accident context, varies widely from country to country. We wish to note once again that simply finding traces of cannabis in drivers involved in accidents is not necessarily a sign that its use was the cause of the accident. Nor does the absence of any screening result mean that no one was driving under the influence of cannabis.

The following table, adapted from INSERM results, refers to a number of recent studies in Europe, America and Australia.

Prevalence of impaired driving(ID) when there are accidents [13]				
Country	Population	Detection method	Sample	Prevalence of cannabis (%)
Belgium Meulemans et al., 1997	Casualty accidents (2-wheeled and cars)	Screening: urine Confirmation: urine CG/SM and urine blood comparison	1 879	6 (urine) 3.6 (blood)
Spain Alvarez et al., 1997	Fatal accidents with suspected ID	Screening: immunoassay blood Confirmation: CG/SM blood	979	1.5 not reliable
France, Mura et al., 2001	Casualty accidents (control group: patients)	No screening Confirmation: CG/SM blood	420 (381)	11.2 (10.8)
France, Kintz et al., 2000	Casualty accidents	Screening: urine Confirmation: CG/SM urine and blood, saliva and perspiration tests	198	13.6 (urine) 9.6 (blood)
Italy, Ferrara, 1990	Injuries Friday night checks	Screening: EMIT urine	4 350 500	5.5
Norway, Christophersen, 1995	Injuries, non-fatal accidents	Screening: immunoassay blood Confirmation: CG/SM blood	394	7.5
United Kingdom, Tunbridge, 2000	Fatal accidents (including 516 drivers)	Screening: immunoassay urine Confirmation: CG/SM blood	1 138 516	12 10
Australia, Longo, 2000	Injuries (non-fatal accidents)	Screening: immunoassay blood Confirmation: CG/SM blood	2 500	11
Canada, Cimburra, 1990	Killed		1 169	11
United States, Logan, 1996	Killed		347	11

Three of these studies are particularly interesting. The Mura et al. study (2001) shows a significant difference by driver age: among 18-20 year olds, the Δ^9THC was present in 18.6% of drivers, and in 50% of cases it was present alone (without alcohol). An earlier study by Mura (1999) had shown that cannabis was particularly common among young drivers: from 35% to 43% in the under 30 age group, with an even higher prevalence (43%) for the under 20s, whereas past the age of 35, the prevalence drops to 3%.[14]

[13] Adapted from INSERM (2001) *op. cit.*, pages 171 and 174.

[14] See INSERM, (2001), *op. cit.*, page 172.

The study by Kintz et al. (2000) is interesting primarily because it clearly shows that, after alcohol (13.6%) cannabis is the substance most frequently present among drivers involved in accidents (9.6%). This study also shows that in the whole sample, the incidence of cannabis as measured by taking a blood sample (9.6%) is close to the level of driving under the influence of alcohol (10.6%).[15]

Then, Longo's study is of special interest because of the size and representativeness of the sample and the fact that separate analyses were done of Δ^9THC and Δ^9THC-COOH. The study detected the presence of cannabinoids in 10.8% of drivers: 8% for Δ^9THC-COOH alone and 2.8% for Δ^9THC-COOH and Δ^9THC together, thereby showing a lower percentage of positive tests for Δ^9THC than the other studies. Furthermore, as in the other studies, subjects testing positive to Δ^9THC were younger and more often men.

Closer to home, Mercer and Jeffery examined the toxicological analyses for 227 drivers killed in traffic accidents in British Columbia between October 1999 and September 1991.[16] Samples had been taken during autopsies within 24 hours of death, which according to the authors, may indicate an under-estimation of the presence of alcohol or drugs. Of the 227 people killed, 186 (43%) showed no signs ofeither alcohol or drugs, 83 (37%) alcohol only, 23 (11%) alcohol and drugs, and 21 drugs only. As for cannabis, 29 of the people killed (13%; 26 men and 3 women) tested positive to Δ^9THC-COOH, showing an average concentration of 15.9 ng/ml. In the +alcohol/+drugs group, (23 subjects), 17 tested positive to THC metabolites and 8 were also positive to Δ^9THC (13%). For the 0alcohol/+drugs group, (21 subjects), 8 (all men) were positive to Δ^9THC–COOH, and 4 to Δ^9THC. Even though the authors concluded that Δ^9THC /Δ^9THC-COOH was present in 13% of cases, which is a percentage comparable to most of the other studies, only 12 subjects killed tested positive to Δ^9THC with or without alcohol and only 4 without alcohol.

Lastly, a more recent epidemiological study dealt with 1,158 cases of fatal accidents (391) or of cases of driving under the influence of psychoactive substances when the percentage of alcohol in the blood was below 0.1 (767) reported in Canadian forensic laboratories on November 12, 1994.[17] The most frequent substances identified were benzodiazepines (590 cases), alcohol (580), cannabis (551), stimulants (224), opiates (176) and barbiturates (131). For cannabis, we get the following table:

[15] *Ibid.*

[16] Mercer, W.G. and W.K. Jeffery (1995) "Alcohol, Drugs and Impairment in Fatal Traffic Accidents in British Columbia" *Accid. Anal. And Prev.*, 27 (3), pages 335-343.

[17] Jeffery, W.K. et al. (1996) "The involvement of drugs in driving in Canada: An update to 1994." *Can. Soc. Forens. Sci. J.*, 29 (2), pages 93-98.

Presence of cannabis in Canada (1994)			
	Total	with alcohol	without alcohol
THC			
➢ **Impaired driving**	181	129	52
➢ **Death**	198	98	100
THC-COOH			
➢ **Impaired driving**	127	29	98
➢ **Death**	45	24	21

In all, cases in which Δ^9THC without alcohol was present accounted for 13% of the total, which is close to the figure found in the other studies.

Out of all the studies, it was found that the presence of cannabis among drivers who were injured or killed varies between 3.6% (confirmed by blood analysis) and 13% (unconfirmed). Where there was confirmation of the presence of Δ^9THC compared to Δ^9THC-COOH, the presence of the active substance decreases by half. In addition, the risk of testing positive is much higher for young men than other drivers. These conclusions are largely shared by other authors.[18]

Epidemiological studies on youth

In recent years, epidemiological studies on youth in the school environment have asked questions about the frequency of driving under the influence of psychoactive substances, cannabis in particular. In Ontario, the 2002 OSDUS study described in Chapter 6 shows that 19.3% of the students had driven their car one hour or less after having taken cannabis at least once in the past twelve months.[19] More interesting is that this compares with 15% who said they had taken their car less than an hour after one or two drinks. In Manitoba, the survey of youths in school reveals that almost 20% see nothing wrong in driving after taking cannabis.[20]

---

[18] Including the INSERM report (2001), *op. cit.*; Ramaekers, J.G. et al., (2002) "Performance impairment and risk of motor vehicle crashes after cannabis use" in Pelc, I. (ed.) *International Scientific Conference on Cannabis*, Brussels.

[19] Adlaf, E.M. et A. Paglia (2001) *Drug Use among Ontario Students 1997-2001. Findings from the OSDUS.* Toronto: Centre for Addiction and Mental Health, page 134.

[20] Patten, D., et coll., (2000) *Substance Use among High School Students in Manitoba.* Winnipeg: Addictions Foundation of Manitoba.

Finally, the Cohen and Kaal study on long term consumers had shown that no less than 42% of the respondents in Amsterdam and 74% in San Francisco had driven their car under the influence of cannabis.[21]

Risk assessment

Given the difficulties of conducting reliable epidemiological studies on driving under the influence of cannabis, a number of authors have analyzed the probability of responsibility and the risk ratio involved in the use of cannabis. These studies distinguish between drivers who are responsible for accidents and those who are not. The former are the subjects and the latter the control group. Comparisons are then made of their intoxication to various substances. Clearly, placing drivers into the two categories of responsible/not responsible may depend on an investigator's perception of whether or not psychoactive substances are present.

The following table, which is reproduced from the Ramaekers et al. report (2002) for the International Scientific Conference on Cannabis summarizes the results of various studies.[22] It should be pointed out that the probability of responsibility for drivers showing traces of cannabis (Δ^9THC and/or Δ^9THC–COOH, whether measured in blood or urine) is compared to the responsibility of drivers involved in an accident not testing positive to any substance (including alcohol). The risk ratio for drivers not testing positive to any substances is 1.0 and is used as a point of comparison to determine the statistical significance of observed change in the risk level of impaired drivers. When the reference value is above the statistical confidence level of 95%, the obvious conclusion is that the drug is 95% associated with an increased risk of responsibility.

Level of culpability relative to driving under the influence of cannabis

Authors	Substance	Odds ratio	Confidence interval at 95%	N of drivers culpable / not culpable
Terhune & Fell (1982), U.S.	Drug free cases	1.0		94/179
	Alcohol	5.4*	2.8 – 10.5	45/16
	THC	2.1	0.7 – 6.6	9/8
	Alcohol/THC	-		-
Williams et al. (1985), U.S.	Drug free cases	1.0		55/23
	Alcohol	5.0	2.1 – 12.2	120/10
	THC or THC-COOH	0.2	0.2 – 1.5	10/9
	Alcohol/THC or THC-COOH	8.6*	3.1 – 26.9	123/6

[21] Cohen, P.D.A. et H.L. Kaal (2001) *The Irrelevance of Drug Policy. Patterns and careers of experienced cannabis use in the populations of Amsterdam, San Francisco and Bremen.* Amsterdam: University of Amsterdam, CEDRO, page 68.

[22] Ramaekers et al. (2002), op.cit., page73.

Terhune et al. (1992), U.S.	Drug free cases	1.0		541/258
	Alcohol	7.4*	5.1 – 10.7	587/38
	THC	0.7	0.2 – 1.8	11/8
	Alcohol/THC	8.4*	2.1 – 72.1	35/2
Drummer (1994), Australia	Drug free cases	1.0		392/140
	Alcohol	5.5*	3.2 – 9.6	261/17
	THC-COOH	0.7	0.4 – 1.5	29/14
	Alcohol/THC-COOH	5.3*	1.9 – 20.3	59/9
Hunter et al. (1998), Australia	Drug free cases	1.0		944/821
	Alcohol	6.8*	4.3 – 11.1	173/22
	THC			
	➢ **≤ 1.0 ng/ml**	0.35	0.3 – 2.1	2/5
	➢ **1,1 – 2,0 ng/ml**	0.51	0.2 – 1.4	7/12
	➢ **> 2 ng/ml**	1.74	0.6 – 5.7	12/6
	THC-COOH			
	➢ **1 – 10 ng/ml**	0.69	0.5 – 2.2	19/24
	➢ **11 – 20 ng/ml**	1.04	0.4 – 2.1	18/15
	➢ **21 – 30 ng/ml**	0.87	0.6 – 4.8	12/12
	➢ **> 30 ng/ml**	1.62	0.6 – 4.8	13/7
	Alcohol/THC	11.5*	4.6 – 36.7	66/6
Lowenstein & Koziol-McLain (2001), U.S.	No substance	1.0		114/126
	Alcohol	3.2	1.1 – 9.4	17/6
	THC-COOH	1.1	0.5 – 2.4	17/17
	Alcohol/THC-COOH	3.5*	1.2 – 11.4	16/5
Drummer et al. (2001) & Swann (2000), Australia	No substance	1.0		1209/372
	Alcohol	5.7*	4.1 – 8.2	720/39
	THC	3.0*	1.2 – 7.6	49/5
	THC > 5 ng/ml	6.4*	1.3 – 115.7	24/0
	THC-COOH	0.8	0 – 1.3	68/26
	Alcohol/THC	19*	2.6 – 136.1	65/62

The study findings show that cannabis alone does not increase the likelihood of responsibility in an accident. However, most of the studies used a measurement of THC-COOH, an inactive metabolite that can remain in urine for several days. When the authors separated out THC alone, the risk ratio was slightly higher, even though it did not reach the required level of significance. In addition, as the concentration of THC increases, the more the ratio increases, once again suggesting a dose-response relationship. Furthermore, the cannabis and alcohol combination significantly increases risk. Without being able to draw any definite conclusions, there are some signs that their effects are in synergy and not merely additive.

Studies on injured drivers (Terhune (1982) and Hunter (1998)) have ratios somewhat higher than in the other studies on fatal accidents. According to Bates and Blakely (1999), the apparent reduction in the risk of a fatal accident stems from the fact that drivers under the influence of cannabis drive less dangerously, for example by reducing their speed.[23]

To conclude, we are rather in agreement with INSERM concerning these studies:

> [translation] *The findings definitely confirm the significant risk of alcohol, but generally fail to demonstrate that there is an effect of cannabis alone on the risk of being responsible for a fatal accident or an accident involving serious injury. The methodological difficulties that make such a demonstration difficult contribute considerably to the absence of statistically indisputable results. Analyses of responsibility nevertheless suggest that the association between alcohol and cannabis increases the risk of being responsible for an accident, compared to drinking alone; however, this finding needs to be consolidated. Lastly, the most recent data tend to show that there is a risk of becoming responsible at heavy concentrations of* Δ^9*THC. This involves using cannabis immediately before driving, and perhaps applies also to chronic users.*[24]

EXPERIMENTAL STUDIES

Epidemiological studies indicate a relatively high level of driving under the influence of cannabis, between 5% to 12% of drivers, mostly among young men. At the same time, neither these studies nor the responsibility/risk analyses reach clear conclusions concerning the role of cannabis in dangerous driving. Hence the interest in studies on how cannabis affects driving ability and driving itself. Studies on the psychomotor and cognitive skills needed to drive vehicles have measured factors such as: motor coordination, reaction time, attention, visual attention and deductive reasoning. There are two types of studies on driving: simulated studies and field studies, whether on a track, in the city or on a highway. Most studies focus on single doses for recreational users. They use control group protocols and cross-linked protocols, including placebos and comparisons with alcohol. However, they are limited by the fact that they mainly measure the acute effects of single doses, making it difficult to determine whether more experienced users would react in the same way. The following sections examine both types of study.

---

[23] Cited in INSERM (2001), *op. cit.*, page 192.

[24] INSERM (2001), *op. cit.*, page 194.

Non-driving activities

In 1985, Moskowitz published a remarkable synthesis of studies on the psychomotor and cognitive effects of cannabis.[25] In this synthesis, he examined motor coordination, reaction time, tracking and sensory functions. The author observed the following:

- motor coordination, measured by hand stability, body balance and movement accuracy was significantly affected. However, the application of these results to driving a car is limited, except in driving situations that require considerable coordination, such as emergency situations. The limits in terms of dose and number of subjects tested (between 8 and 16) also need to be noted
- reaction time was not significantly changed: "*There are a sufficient number of experiments involving both simple and complex reaction time situations to leave us relatively well assured that neither the speed of initial detection nor the speed of responding are, per se, impaired by marihuana. Rather, when marihuana produces a reaction time increase, there is some dimension of the information processing task which the subject must execute which bears the brunt of the experiment.*"[26] Attention rather than reaction time was affected by marijuana use
- straight line: this dimension was particularly sensitive to the effects of marijuana, and the vast majority of studies showed a significant reduction in the ability to go in a straight line or correct deviations from the line
- the sensory functions (hearing and visual) are often affected, but the studies did not yield precise results concerning the distinction between simple tasks and complex tasks.

Ramaekers et al. (2002), reported a meta-analysis on 87 controlled laboratory studies on the psychomotor effects of cannabis conducted by Berghaus et al. (1998). These authors found that the number of psychomotor functions linked to driving (following, reaction time, perception, hand-eye coordination, body balance, signal detection and divided and continuous attention) affected by THC reached a maximum during the first hour after smoking, and one to two hours after oral ingestion. The maximum figures were comparable to those obtained with an alcohol concentration equivalent to > 0.05 g/dl. The number of functions affected reached zero after three to four hours, and only higher doses continued to have an effect. The studies surveyed also showed that THC concentration in the blood is highly correlated to psychomotor effects: a concentration of between 14 ng/ml and 60 ng/ml affected between 70% and 80% of tasks.[27]

The following table summarizes these data:

[25] Moskowitz, H., (1985) "Marihuana and Driving." *Accid. Anal. Prev.*, 17 (4), pages 323-345.

[26] *Ibid.*, page 330.

[27] Ramaekers J.G. et al. (2002), *op. cit.*, page 77.

Deterioration of performance on psychomotor tests by dose, time and method of ingestion										
THC dose	Time (in hours)									
	< 1		1-2		2-3		3-4		4-5	
	Tests (n)	% affected	Tests (n)	% affected	Tests (n)	% affected	Tests (n)	% affected	Tests (n)	% affected
Smoked										
< 9mg	271	61%	33	36%	10	30%	10	0%	11	0%
9 – 18 mg	193	53%	48	38%	8	38%	6	0%	2	0%
≥ 18 mg	64	64%	28	36%	10	40%	15	53%	3	67%
Total	528	58%	109	37%	28	36%	31	26%	16	13%
Oral										
< 9mg	3	33%	49	14%	37	8%	13	8%	-	-
9 – 18 mg	3	0%	41	39%	45	18%	17	18%	-	-
≥ 18 mg	3	0%	45	60%	15	33%	15	33%	11	45%
Total	9	11%	135	37%	97	20%	45	20%	11	45%

More recently, after surveying the studies carried out in recent years, the reports prepared by INSERM and the International Scientific Conference on Cannabis reached largely similar conclusions: cannabis affects reaction time where choice is involved, road tracking, shared attention and continuous attention, as well as memory processes, but does not significantly affect simple reaction time or visual or eye-movement functions.

While driving

One of the weaknesses of the laboratory studies is the difficulty of relating psychomotor and cognitive tasks directly to driving. Several tests measured in these studies are short and relatively simple and do not necessarily reflect real situations. The advantage of simulated driving studies and field driving studies is that it brings the conditions closer to reality.

Most contemporary studies have similar characteristics: subjects have had a driver's licence for at least three years. They are often regular cannabis users. The subjects receive either cannabis or a placebo in a double-blind situation that is very strictly timed to control the level of THC transmitted. In some instances, the experimenters also include comparisons with alcohol and an alcohol placebo. However, it is impossible to control how much subjects inhale and actually absorb. The cannabis prepared by the U.S. National Institute of Drug Abuse (NIDA) varies between 1.75% THC for low doses, 2.67% for moderate doses and 3.95% for strong doses. Converted into µg/kg of weight, the doses correspond to 100, 200 and 300 µg/kg, whereas the heavy dose usually preferred by regular users is generally 308 µg/kg. The subjects are

familiarized with the equipment used and the tasks to be performed, and are accompanied by instructors on actual driving studies. Measurements include the standard deviation of lateral position in relation to the road, the control over longitudinal position (distance) in relation to the vehicle ahead, decision-making in emergencies, style of driving and risk taking.

The following table, adapted from INSERM data, summarizes a number of the more recent studies.

Effects of cannabis on car driving[28]

Reference / environment	Subject / Dose / Protocol	Tasks	Measurements	Results
Simulator				
Liguori et al., 1998	10 users Placebo Cigarette 1.77% THC smoked in 5 mn Cigarette 3.95% THC smoked in 5 mn Test: 2 mn after Duration: 1 hour	Avoid a barrier that suddenly appears by braking (55 to 60mph)	Total braking time Lag time to take foot off accelerator and step on brake	? Slightly significant at 1.77 THC, slightly more at 3.95 No difference
		Judgment: maintain speed of 30mph on marked road and select widest lane at intersection	Average speed Number of cones knocked over Number of successful choices	No effect
Sexton et al., 2000	15 users Placebo Grass, low dose 1.77% THC Heavy dose: 2.67% THC 1 resin cigarette: 1.70% THC Blood and saliva sample 10 mm after start Test 30 mn Duration: 25 mn	Highway section with vehicle ahead passing	Average reaction time	? At low dose (high level of variability at heavy dose: ns)
		Highway section with vehicle ahead braking	Average reaction time	? At low dose (ns)
		16.7 km of highway section	Maximum, minimum and average speed	? Average of 6mph at low and heavy dose
		Left and right turns	Standard deviation for perfect line	? Variation at heavy dose versus low dose or placebo
		Intersection with traffic lights, with 4 lane road	Response time in going through amber	? At heavy dose

[28] Table adapted from INSERM (2001) *op. cit.*, pages 183-184.

Effects of cannabis on car driving[28]

Reference / environment	Subject / Dose / Protocol	Tasks	Measurements	Results
			Average waiting period at a point 10m from the stop line	? At heavy dose (high level of variability: ns)
Actual driving				
Robbe, 1998 study No. 1 Closed portion of highway (cannabis)	24 users Placebo 100, 200 and 300 Test: 40 mm and 1 hour 40 mm after	Constant speed at 90km/hr and tracking over 22km	Standard deviation of lateral position	? Instability at all 3 doses
			Average lateral position deviation	No effect
			Average speed and standard deviation	No effect
Study No. 2 Normal traffic on highway (cannabis)	16 users same doses as study 1 Test: 45 mn after	Tracking control (Ibid.) 64km, 50 mn	Same measurements	Same effects
		Following cars over 50m at variable speed (between 80 and 100km/h) over 16 km, 15 mn	Average reaction time	? ns
			Average distances and standard deviations	Distance increased by 8, 6 and 2 m for 100, 200 and 300 THC
Study No. 3 City driving (cannabis)	16 users Placebo 100 Test: 30 mn after	City driving 17.5 km Dense, moderate or light traffic	External observations	No significant change
			Internal observations: skill, manoeuvres, turns…	No effect
Study No. 3 City driving (alcohol)	16 users Placebo Alcohol level: 0.5 g/l	Ditto	External observations	No significant change
			Internal observations: skills, manoeuvres, turns…	0.34 g/l alcohol level modifies control and manoeuvres
Robbe, 1998 Highway driving (cannabis and alcohol)	18 users THC: 100, 200 Alcohol: 0.4 g/l Preparation: Alcohol 0 + THC 0 Alcohol) + THC 100 Alcohol 0 + THC 200 Alcohol 0.4 + THC 0 Alcohol 0.4 + THC 100	Tracking: speed at 100km and constant lateral position	Standard deviation of lateral position	? Tracking variability; low alcohol alone, THC 100 alone; Moderate: THC 200 Heavy: alcohol 0.4 and THC two doses

Effects of cannabis on car driving[28]				
Reference / environment	**Subject / Dose / Protocol**	**Tasks**	**Measurements**	**Results**
	Alcohol 0.4 + THC 200 Alcohol plus cannabis 60 mn after Tests between 9:00 p.m. and 11:15 p.m.	Following: follow a vehicle over 50 m with speed varying by ± 15km/hr every 5mn	Reaction time	? Reaction time for 0.4 alcohol and THC 200
		Driving in traffic	Average distances and standard deviations	? Variability in distance between cars in all cases
Lamers and Ramaekers, 2000 City driving (cannabis and alcohol)	16 users THC 100 Alcohol 0.5 g/l 4 preparations:	City driving 15 km	Frequency of appropriate eye movements	No effect with alcohol alone or cannabis alone
	Alcohol 0 + THC 0 Alcohol 0.5 + THC 0 Alcohol 0 + THC 100 Alcohol 0.5 + THC 100 Tests: 15 mn after Duration: 45 mm	Visual search monitoring	Quality of driving	? Performance if alcohol + cannabis No effect

It is interesting to recall that one of the first driving studies on the road was conducted for the Le Dain Commission.[29] In this study, on a closed track, 16 subjects were each given the 4 following preparations: placebo, marijuana 21 and marijuana 88 μg/kg THC and a dose of alcohol equivalent to BAC 0.07. The tests were conducted immediately after use and three hours later. The subjects were to complete six circuits of the track (1.8 km) with manoeuvres involving slowing down while going forward and backwards, maintaining a trajectory and weaving through cones. The alcohol and heavy dose of marijuana decreased driver performance in tests conducted immediately after use. At the heavy cannabis dose, drivers drove more slowly. On the second test, the differences were less clear.

When the results of this study are compared to those conducted more recently using much more sophisticated methods, it can be seen that the results are remarkably similar.[30] Thus the following was observed:

- lateral control: this is the variable that is most sensitive to the effects of THC, but the effects are variable, depending on the dose and time; only heavy doses significantly affected lateral control over the vehicle. In comparison,

[29] See Hansteen, R.W, et al. (1976) "Effects of cannabis and alcohol on automobile driving and psychomotor tracking." *Annals of the New York Academy of Science*, 282, pages 240-256.
[30] See notably the survey of studies and the discussion in Smiley, A., (1999) "Marijuana: On-Road and Driving Simulator Studies" in Kalant, H. et al., (ed) *The Health Effects of Cannabis*. Toronto: Addiction Research Foundation, pp. 173 passim.

alcohol has a greater effect on vehicle lateral control and speed (linked variables)

- speed control: in almost all cases, the use of cannabis significantly decreases speed
- risk-taking: in addition to decreasing speed, it is generally found that there is an increase in distance between vehicles among marijuana users, and less of a tendency to pass or attempt dangerous manoeuvres
- decision time: this variable is particularly important in actual driving situations. The results do not appear to be very consistent. Smiley suggests that reaction time is unaffected when the subjects are told that they need to respond rapidly, whereas on the other hand, when the obstacles are completely unexpected, the subjects who used cannabis do not perform as well
- combined effects of alcohol and cannabis: when the researchers checked the effects of the two substances, the combined effects of cannabis and alcohol were systematically greater than alcohol alone or, even more so, than cannabis alone.

Lastly, with low doses, subjects had the impression that their driving was not as good as observers felt it was, which was not necessarily the case with higher doses, where the perceptions of both the drivers and the observers agreed.

CONCLUSIONS

The Committee feels it is likely that cannabis makes users more cautious, partly because they are aware of their deficiencies and they compensate by reducing speed and taking fewer risks. However, because what we are dealing with is no longer the consequences on the users themselves, but the possible consequences of their behaviour on others, the Committee feels that it is important to **opt for the greatest possible caution** with respect to the issue of driving under the influence of cannabis. Given what we have seen in this chapter, we conclude the following.

Conclusions of Chapter 8	
Epidemiological data	➢ **Between 5% and 12% of drivers may drive under the influence of cannabis; this percentage increases to over 20% for young men under 25 years of age.** ➢ **This in itself does not mean that drivers under the influence of cannabis represent a traffic safety risk.** ➢ **A not insignificant percentage of drivers test positive for cannabis and alcohol together.**

Data on effects on driving	➢ Cannabis alone, particularly in low doses, has little effect on the skills involved in automobile driving. ➢ Cannabis, particularly in the doses that match typical doses for regular users, has a negative impact on decision time and trajectory. ➢ Cannabis leads to a more cautious style of driving. ➢ The effects of cannabis when combined with alcohol are more significant than for alcohol alone.
Testing	➢ Blood remains the best medium for detecting the presence of cannabinoids. ➢ Urine cannot screen for recent use. ➢ Saliva is promising, but rapid commercial tests are not yet reliable enough. ➢ The visual recognition method used by police officers has yielded satisfactory results.
Further studies	It is essential to conduct studies in order to: ➢ Develop a rapid testing tool. ➢ Learn more about the driving habits of cannabis users.

CHAPTER 9

USE OF MARIJUANA FOR THERAPEUTIC PURPOSES

There has been renewed interest in the issue of the use of marijuana for therapeutic purposes in recent years, particularly in Canada. In the wake of an Ontario Court of Appeal ruling which found the provisions of the *Controlled Drugs and Substances Act* to be unconstitutional pertaining to the therapeutic use of marijuana, the federal Health Minister made new regulations in July 2001 that give people with specified medical problems access to marijuana under certain conditions. Later that same year, an international conference on medicinal cannabis held in The Hague, Netherlands, drew delegates from Canada and several other Western countries.[1] Earlier, in 1999, the National Institute of Medicine in the United States published an assessment of the science base of marijuana and medicine.[2]

However, the scientific community – the medical community in particular – is divided on the real therapeutic effectiveness of marijuana. Some are quick to say that opening the door to medical marijuana would be a step toward outright legalization of the substance. Witness the following two quotes, the first of which is from a former director of the National Institute on Drug Abuse (NIDA) in the United States:

> *It is primarily the political muscle of the marijuana legalization proponents that today creates the motivation to do additional research on marijuana smoke. [...] There is one explanation for the strident insistence of marijuana legalization proponents that only smoked marijuana will do as 'medicine'. They appear to be determined to have sick medical patients smoking marijuana in the public eye. They want that outcome because that act legitimizes the use of marijuana by changing the common public perception of marijuana from a harmful drug to a useful medicine.*[3]

> *Although many who champion medical marijuana use do so on compassionate grounds, with the firm conviction that smoked marijuana provides benefits unavailable by other means, much support comes from those who advocate the liberalization of drug policy and the decriminalization of drug use.*[4]

---

1 *International Conference on Medicinal Cannabis*, November 22-23, 2001, The Hague, Netherlands.

2 Joy, J.E., S.J. Watson and J.A. Benson (1999) (eds.), *Marijuana and Medicine: Assessing the Science Base.* Washington, D.C.: National Academy Press.

3 DuPont, R.L. (1999), "Examining the Debate on the Use of Medical Marijuana", *Proceedings of the Association of American Physicians*, Volume 111, No. 2, page 169.

4 Rosenthal, M.S., and H.D. Kleber (1999), "Making Sense of Medical Marijuana", *Proceedings of the Association of American Physicians*, Volume 111, No. 2, page 159.

It is true, as Professor Mark Ware pointed out in his testimony before the Committee, that in the current legal and political context, it is difficult to conduct studies and, more importantly, do so without being influenced by the heated debate over marijuana.

> *Let us look at the effect that current drug policy has had on our understanding of cannabis. All our data on the health effects of cannabis have been collected under a paradigm of prohibition. This may seem self-evident but it constitutes an important source of bias. In examining the health effects of cannabis, an estimate of the use of cannabis in the healthy population is important. [...] Surveys of illicit drug use are notorious for poor response rates. It hampers our ability to draw conclusions on what cannabis does, if we don't really know who is doing it. It is important to estimate the size of the bias, and the effect it has had, and good research will always try to minimize it. However, in my experience of critically reviewing the literature on cannabis effects on health, examples exist where important estimates of risk are based on studies which have inappropriate control selection. [...] The question therefore changes from 'how has cannabis policy affected health?' and becomes 'has cannabis policy affected our understanding of the health effects of cannabis?'*[5]

It is also true that the issue of medicinal marijuana challenges us on the very concept of modern medicine and its links with the pharmaceuticals industry, since research on cannabinoids has already led to the development of synthetic THC compounds. Drug companies are known to have played a major role in international negotiations leading to the adoption of the first international conventions on the control of psychoactive substances.[6] Moreover, the marijuana plant itself, because it cannot be patented, is of no interest to major pharmaceutical research groups.

Beyond the scientific "proof" that marijuana is effective and the prospect of physicians prescribing marijuana with sufficient confidence, many people believe, based on personal experience, that marijuana has a direct impact in terms of improving their well-being with minimum adverse effects. That view is what led to the creation of "compassion clubs", organizations that distribute marijuana to growing numbers of clients. One of the questions this raises is how much evidence is needed before people can be allowed to freely use marijuana to relieve a medical condition. Indeed, do we have to think of marijuana in strictly medical terms?

We saw in Chapter 7 that the long-term effects of using marijuana, even on a regular basis, are limited and that even the most serious effects, such as lung cancer, have yet to be clearly demonstrated. We also saw that the adverse effects of prolonged use on cognitive function are more prevalent in people who are already vulnerable because of their young age when they started using, for example, or their personal condition (for example, psychotic predispositions). We also saw that, even assuming

---

[5] Dr. Mark Ware, Assistant Professor of Family Medicine and Anesthesia, McGill University, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, May 31, 2002.

[6] See in particular the study by W.B. McAllistair, *Drug Diplomacy in the 20th Century*. This point will be discussed later in chapter 19.

some tolerance and a certain level of psychological dependency, those effects are minor, the signs of withdrawal minor, and treatment shorter and less often necessary than for other drugs. To a degree, it appears that the psychoactive properties of marijuana, which some see coupled with rejection of society, others with a weak personality and still others with immoral behaviour, make the substance suspect, whether in medical or non-medical applications.

In that sense, the issue of medical marijuana is not so much a question of legalization through the back door as it is a question of open examination of each person's underlying conception of the "drug". In a way, it is a prime opportunity to explore our preconceptions and prejudices. Stating, as we did in Chapters 6 and 7, that the psychological, physiological or social effects of marijuana use are by all indications relatively benign says nothing about the therapeutic benefits of the plant in the same way that medical uses of the poppy say nothing about the individual or social harm that can be caused by heroin. Dr. Kalant echoed this view:

> *The separation of the control methods between medical and non-medical use is generally clearly understood. Both heroin and cocaine have limited but recognized medical uses. [...] Yet, nobody argues that, because these drugs have some limited medical use, that they should therefore be legalized for non-medical use. [...] Cannabis is perhaps the one exception in which possible medical uses are often claimed by some proponents of legalization of cannabis as a justification for legalization for non-medical use. This to me seems quite irrational. There is no logical reason why having a medical use should be any argument at all, either for or against, availability for non-medical use.*[7]

However, as Dr. Ware reiterated, "*the safety of cannabis in humans has been extensively studied, thanks in part to the massive Western cohort of 'healthy human volunteers' of the last 40 years. Cannabis may have undergone the most extensive and unorthodox Phase I clinical trials of any drug in history.*"[8] While it is true that research protocols to allow medical use of a substance are and must remain rigorous, there is no clear boundary between the two areas of research. This was illustrated to some extent in the review in Chapter 7 of studies on the effects and consequences of marijuana. Indeed, the opposite approach struck us as more common, where, based on the presumed harmful effects of marijuana on psychological and physical health, the therapeutic usefulness of marijuana becomes at least suspect. We take as an example the position of the Canadian Medical Association.

In his testimony before the Commission, current CMA president Dr. Henry Haddad said:

---

[7] Dr. Harold Kalant, Professor Emeritus at the University of Toronto, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, June 11, 2001, Issue 4, pages 70-71.

[8] Dr. Mark Ware, *op.cit.*

While our understanding of all the possible long-term health effects that prolong Canada's use is still evolving, what we do know is troubling. The health risks range from acute effects such as anxiety, dysphoria, or the feeling of being ill; cognitive impairment to the chronic effects such as bronchitis, emphysema and cancer. Canada's youth have also been subject to pulmonary damage comparable to that produced by tobacco use but the effects are much more acute and rapid. Evidence suggests that smoking two or three cannabis cigarettes a day has the same health effect as smoking 20 cigarettes a day. Therefore, the potential long-term health effects of cannabis use could be quite severe.

The CMA's concerns regarding the impact of cannabis are in part why we are opposed to the federal government's current medical marijuana access regulations. In our May 7, 2001, letter to the Minister of Health, the CMA noted 'lack of credible information on the risks and benefits of medical marijuana.'

During discussions on the government's medical marijuana regulations, we highlighted the health concerns and research that indicates that "marijuana is an addictive substance that is known to have psychoactive effects and in its smoke form is particularly harmful to health."

We have concluded that while benefits of medical marijuana are unknown, the health risks are real. Therefore, it would be inappropriate for physicians to prescribe marijuana to their patients, a position that was supported by the Canadian Medical Association.

[...]

The CMA is concerned that this debate concerning decriminalization and the medical marijuana issue has, to some extent, legitimized its use for recreational purposes. It is important that our message to you regarding decriminalization be clear and understood. Decriminalization must be tied to a national drug strategy that promotes awareness and prevention and provides for comprehensive treatment in addition to research and monitoring of the program.

[...]

The CMA believes that any changes regarding illegal drug policy should be gradual. Like any other public health issue, education and awareness of the potential harms associated with cannabis and other illegal drug use is critical to reducing drug usage.[9]

If we were to succeed in showing that the effects are not as bad as had been thought, would it change in any way the issues related to medical use of marijuana? The acute effects identified by the CMA are possible but relatively rare and often the product of personal predispositions, context or a particular crop of marijuana. In fact, the primary acute reactions, the reactions documented by most of the research, are pleasant and help the user relax. If we were to convince the medical association that marijuana is not particularly addictive and that even where it is, the effects are relatively benign, would that clear the way for medical use of marijuana? Aside from the fact that

[9] Dr. Henry Haddad, President, Canadian Medical Association, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, March 11, 2002, Issue 14, pages 52-53 and 54-55.

marijuana is only tenuously linked to "drug addiction", there is by no means consensus in the scientific community on the very notion of drug addiction, viewed primarily as a disease.

The question lies elsewhere – in two places, in fact. First, knowledge of the potentially harmful effects of marijuana says nothing about the qualities of the plant as a medicine. To be sure, knowledge of the secondary effects of drugs, including their addictive potential, is essential to the pharmacopoeia. However, those substances must first be established as drugs, particularly in terms of effectiveness and reliability. Second, the whole issue is broached as if resistance to medical use of marijuana were based not so much on the absence of medical knowledge *per se* – which is the case to some extent, as we will see later in this chapter – as on the link between marijuana and drug addiction. From that perspective, the issue is quickly resolved: in keeping with the medical maxim *"first do no harm"*, a physician will not prescribe a treatment the effects of which could lead to an illness at least as serious as the illness being treated in the first place. If marijuana is listed as an illegal drug, banned in some contexts because of its harmful effects and capable of leading to drug addiction, what compelling arguments could be put forward to "save" medical marijuana?

But none of that should matter to physicians or scientists. It is not a question of defending general public policy on marijuana or even all illegal drugs. It is not a question of sending a symbolic message about "drugs". It is not a question of being afraid that young people will use marijuana if it is approved as a medicine. The question – the only question – for physicians is whether, to what extent and in what circumstances, marijuana serves a therapeutic purpose. Physicians would have to determine whether people with certain diseases would benefit from marijuana use and weigh the side effects against the benefits. If they decide the patient should use marijuana, they then have to consider how he or she might get it. The issue of deciding whether cannabis has therapeutic benefits is obviously clouded by the current legal context on cannabis. This may be inevitable, but those who take public positions on cannabis for therapeutic purposes should say so.

The rest of this chapter is devoted to the history of the use of marijuana for therapeutic purposes and the status of contemporary knowledge of marijuana and synthetic cannabinoids. We then give a brief account of compassion clubs and other organizations that supply marijuana for therapeutic use, as well as various public policy regimes. We conclude with our views on medical use of marijuana. In a later chapter, we discuss which public policy regime would be most appropriate given the status of medical use of marijuana.

History

The therapeutic potential of marijuana has apparently been known since the beginning of recorded history. In fact, marijuana was likely used for medicinal purposes even before its psychoactive properties were tapped.

The medical history of marijuana is closely related to its analgesic properties, as noted by Ethan Russo:

> *Cannabis has a history as an analgesic agent that spans at least 4000 years, including a century in mainstream Western medicine. [...] The reasons lie in the remarkable pharmacological properties of the herb and new scientific research reveals the inextricable link that cannabinoids possess with our own internal biochemistry. In essence, the cannabinoids form a system in parallel with that of the endogenous opioids in modulating pain. More important, cannabis and its endogenous synthetic counterparts may be uniquely effective in pain syndromes in which opiates and other analgesics fail.*[10]

According to Russo, written documents and ethnographic traces of medical use of marijuana have been found in many countries. In China, a second-century medical paper reported that marijuana was used as a surgical anaesthetic. In India, marijuana was been used to treat migraines and chronic pain 2000 B.C. In Egypt, where most scholars thought that marijuana had not been introduced, there is evidence that it had been in use in medicine since the days of the pharaohs; traces of marijuana were found in the tombs of Amenophis IV and Ramses II. Marijuana was apparently used to treat glaucoma and labour pain. Marijuana was administered orally, rectally or vaginally, applied to the skin, inserted in the eyes and smoked.

In Assyria, Babylonia and Arcadia, marijuana was apparently used as an analgesic to treat migraines and menstrual pain and for its psychoactive properties. Evidence of marijuana use to control labour pain has also been found in Palestine and Israel. The Greeks and Romans used marijuana for general pain control and specifically for gout and rheumatism. In the Muslim world, there are references to therapeutic use dating back to the ninth century.

In the mid 17th century, western medicine discovered the medicinal properties of marijuana. A compendium of plants published in 1640 in England made reference to marijuana being used in the form of a paste containing essence from the plant and other ingredients. In France, the work on hemp published by Mercandier described a number of uses: dried and applied as a plaster, it eased the pain associated with tumours; boiled and applied as a plaster, it helped ease the pain of rheumatism, gout and various muscle inflammations; crushed into a powder and mixed with butter, it

---

[10] Russo, E.B. (2002), "The role of cannabis and cannabinoids in pain management", in Weiner, R.S. (ed.), *Pain Management. A Practical Guide for Clinicians*, Boca Raton, London, New York, Washington: CRC Press.

soothed burns. In his classification of plants, Linnée recognized the medicinal properties of marijuana as a pain reducer.

Medical use of marijuana became more widespread in England in the middle of the 19th century when the plant was brought back from India. Even the personal physician of Queen Victoria, Russell Reynolds, used it: he treated his celebrated patient for dysmenorrhea throughout her adult life using cannabis extract. In an 1868 paper, he wrote that unlike opiates, marijuana could be used today without causing problems tomorrow.[11]

Between 1890 and 1940, English, Irish, French and then American physicians and pharmacists testified in different ways to the usefulness of various marijuana preparations in relieving pain. One British pharmacologist even reintroduced the smoking of marijuana in 1899, pointing out that smoking was particularly useful if an immediate effect was desired.[12]

Marijuana is still part of the pharmacopoeia, at least informally, of many countries in southeast Asia. Marijuana use in India was recently described as follows:

> *Charas is the resinous exudation that collects on the leaves and flowering tops of plants (equivalent to the Arabic hashish); it is the active principle of hemp; it is a valuable narcotic, especially in cases where opium cannot be administered it is of great value in malarial and periodical headaches, migraine, acute mania, whooping cough, cough of phtisis, asthma, anaemia of brain, nervous vomiting, tetanos, convulsion, insanity, delirium, dysuria, and nervous exhaustion; it is also used as an anaesthetic in dysmennorhea, as an appetizer and aphrodisiac, as an anodyne in itching of eczema, neuralgia, severe pains of various kinds of corns, etc.* [13]

It is also used in Colombia, Jamaica and Brazil.

It is tempting, of course, enamoured as we are with our modern science, to dismiss these traditional uses as "home remedies" – and the stuff of quacks. However, the fact that marijuana has been used so long for the same types of condition, that it has sometimes been described so accurately, that it has transcended cultures and histories, and that modern medicine suggests that marijuana could in fact be useful in treating the chronic pain associated with various medical conditions should stop us from being too cynical about these "old-fashioned" uses.

---

[11] Quoted in Russo, *op. cit.*, page 359.

[12] *Ibid.*, page 360.

[13] *Ibid.*, page 361.

CONTEMPORARY KNOWLEDGE

Two questions strike us relevant here. The first is whether marijuana in fact has the therapeutic effects that have been ascribed to it traditionally and more recently in the personal stories of people suffering from chronic pain and other conditions. If those benefits are real, the second question, altogether different and based on different criteria, is whether marijuana should be considered a drug.

Therapeutic uses

Knowledge of the mechanics of cannabinoids and the endogenous cannabinoid system allows a number of observations to be made. Generally, and bearing in mind what was written in Chapter 5, the action of cannabinoids can be described as follows:

> *[...]the overall effect is that of a cellular inhibition rather than cellular activation. It settles down nerve firing through a number of different types of reactions, primarily through changes that lead to changes in the flow of ion channels, which changes the firing behaviour of the cell which then changes how it communicates with other cells down the line.*
>
> *Opening of potassium channels with decreased cell firing and closing of calcium channels with decreased release of neurotransmitters or overall cellular inhibition, which quiets things down. Those could have major therapeutic implications in certain clinical situations, such as pain and spasticity. They have implications in settling down nerve firing within pain conducting systems.* [14]

More specifically, cannabinoids act on various neurophysiological systems associated with pain, either alone or in combination with the endogenous opiate system.[15] Cannabinoids affect the release of serotonin, which is itself associated with different types of pain, migraines in particular. Anandamide and other cannabinoid antagonists block the release of serotonin and ketanserin, both of which are linked to migraines, suggesting the potential effect of THC. Cannabinoids are also related to the dopamine system, which has been linked with migraines and other types of pain. Further, cannabinoids inhibit prostaglandin, producing an anti-inflammatory effect. Some studies have shown that THC is in that sense a more powerful analgesic than aspirin or even cortisone. Interacting with the endogenous opioid systems, cannabinoids increase the production of beta-endorphins, which reduce the effect of migraines. According to some studies, THC may have greater therapeutic potential than

---

[14] Dr. Mary Lynch, Director, Canadian Consortium for the Investigation of Cannabinoids, Professor, Dalhousie University, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, June 11, 2001, Issue 4, page 49.

[15] The following information is taken primarily from Russo, *op. cit.*, Hartel, C.R., "Therapeutic Uses of Cannabis and Cannabinoids", in Kalant, H. (ed.), *The Health Effects of Cannabis*, Toronto: Addiction Research Foundation, and INSERM (2001), *op. cit.*

morphine, either because the applications would be more specific in some cases, because in other cases morphine aggravates some symptoms, or because THC lacks the sedative properties of morphine. Moreover, THC may have an antinociceptive effect on the periaqueductal grey. Finally, THC acts as a glutamate blocker and thereby reduces muscle and inflammatory pain.

> *Italian researchers Nicolodi, Sicuteri and colleagues have recently elucidated the role of NMDA antagonists in eliminating hyperalgesia in migraine, chronic daily headaches, fibromyalgia, and possibly other mechanisms of chronic pain. Gabapentin and ketamine were suggested as tools to block this system and provide amelioration. Given the above observations and relationships, it is logical that prolonged use of THC prophylactically may exert similar benefits, as was espoused in cures of chronic daily headache in the 19th century with regular use of extract of Indian hemp.* [16]

In real terms, these mechanisms mean that cannabinoids can be beneficial in a number of situations that involve pain, but not pain alone The following are foremost among them.

- **Emisis**: Nausea is a common condition in cancer patients undergoing chemotherapy. As a result of a series of clinical trials involving people who reported using marijuana to relieve their vomiting, synthetic dranobinol (or Marinol) and nabilone (or Cesamet) were developed and tested primarily in the United States and Great Britain beginning in the 1970s. According to Dr. Lynch, *"cannabinoids are thought to be modest antiemetics. There are more effective antiemetic agents available. However, because antiemetics work through a number of different mechanisms and because often we need to be able to target more than one mechanism to treat nausea and vomiting, cannabinoids are looking like they may be useful because they may offer us another option."*[17]

- **Cachexia**: A significant number of people with AIDS/HIV suffer progressive anorexia coupled with weight loss. Some studies show that cannabinoids can help improve their situation, mainly because THC increases appetite. Some reservations have been voiced regarding the harmful effects of smoked THC on the immune system: *"More recently, Nieman et al (1993) have shown that cigarette smoking by HIV seropositive individuals is associated with a more rapid development of AIDS because smoking increases the incidence of Pneumocystis carinii pneumonia (PCP)."*[18] Others, however, have come to different conclusions: *"A particular public health concern surrounds cannabis effects on HIV/AIDS. Four studies among others may reduce related concern. Kaslow et al. (1989) demonstrated no evidence that cannabis accelerated immunodeficiency parameters in*

---

[16] Russo, *op. cit.*, page 365.

[17] Dr. Mary Lynch, *op. cit.*, page 52.

[18] R.D. Hartel, *op. cit.*, page 465.

HIV-positive patients. DiFranco et al. (1996) ascertained no acceleration of HIV to full-blown AIDS in cannabis smokers. Whitfield, Bechtel and Starich (1997) observed no deleterious effects of cannabis usage in HIV/AIDS patients, even those with the lowest CD4 counts. Finally, Abrams et al. (2000) studied the effects of cannabis smoking on HIV-positive patients on protease inhibitor drugs in a prospective randomized, partially blinded placebo-controlled trial. No adverse effects on CD4 counts were observed secondary to cannabis."[19]

- **Glaucoma**: Glaucoma is an eye disease in which intraocular pressure builds because the fluid in the eye has difficulty draining and which leads to gradual destruction of the ocular nerves. Marijuana, in particular paste made from cannabis leaves, has been used to reduce intraocular pressure since ancient times, as we saw in the previous section. Recent studies suggest that marijuana – including smoked marijuana – helps reduce the effects of glaucoma. However, there have been some reservations because of some of the side effects of smoking marijuana (redness and drying of the eyes). In a case study by Russo *et al.* on four patients who smoked marijuana, one patient with glaucoma stated in court that the marijuana saved her sight.

- **Spasms and convulsions**: The anticonvulsive properties of marijuana that help control epileptic seizures and the antispasm properties that are useful in treating multiple sclerosis are well known in Canada; marijuana use for epilepsy gave rise to the Ontario Court of Appeal decision in Parker. Smoked marijuana and synthetic cannabinoids appears to be effective in controlling these conditions. However, because of the bioavailability of synthetic compounds (between 20% and 30%) and their delayed effect relative to smoked marijuana, patients seem to prefer smoking.

- **Pain**: The analgesic effects of marijuana in easing different types of pain have also been known since ancient times. We described the analgesic effect of marijuana above. More importantly, marijuana has specific effects on some types of pain that opiates do not.

Marijuana as a drug?

In order for a product to be recognized as a drug in the pharmacopoeia, it must meet at least three criteria:

---

[19] Russo, E.B., *et al.* (2002), "Chronic cannabis use in the compassionate investigational new drug program: An examination of benefits and adverse effects of legal clinical cannabis", *Journal of Cannabis Therapeutics*, Vol. 2, No. 1, page 45.

- Quality: the dosage must be determined based on a constant and known composition that is easy to administer to the patient;
- Effectiveness: rigorous clinical trials must have demonstrated the effectiveness of the drug; and
- Safety: studies must show the known and foreseeable side effects of the drug.

Because of the lack of rigorous clinical studies using recognized protocols, whole marijuana has not yet met these criteria. There are a number of reasons for this. First, the research protocols needed to test drugs involve double-blind tests with control groups and randomly selected subjects, all conditions that are hard to achieve with marijuana. Second, the current legal climate limits the potential for such studies in terms of both the availability of marijuana and test conditions. Third, the marijuana provided by the National Institute of Drug Abuse (NIDA) for medical research – including research conducted by Health Canada – is of dubious quality:[20] THC concentration may be a determining factor in the quality of the therapeutic effects, yet NIDA marijuana contains only 1.8% to 5% THC. Moreover, weaker marijuana requires more draws and releases more CO than marijuana with a higher THC content. Other cannabinoids are not measured, yet they are known to also have a bearing on the medical properties of marijuana. The paper in which the marijuana is rolled is of poor quality. The marijuana is often more than two years old and may not have been stored under conditions that would preserve all its qualities. Finally, the marijuana contains many seeds and other plant debris. Fourth, it is difficult to control the amount of marijuana actually absorbed by the subjects: the way a person draws on the cigarette, whether or not the person is accustomed to smoking, the subject's preferences and the length of time the subject inhales are factors which can affect the test conditions and which researchers have not yet been able to measure accurately.

It must also be possible to answer the following and other questions:

- Is there a difference between synthetic cannabinoids and whole marijuana?
- What is the optimum marijuana profile in a given situation?
- Do different doses and different forms of ingestion produce significantly different effects?

[20] Russo, *op.cit*, discusses these weaknesses in greater detail.

In recent years, analyses of the scientific literature have been conducted by the Institute of Medicine in the United States and the British Medical Society and in various government reports in England, the Netherlands and elsewhere. The Institute of Medicine concluded that there is evidence of the therapeutic potential of marijuana as an analgesic, antiemetic and appetite stimulant. It noted, however, that smoking is a difficult way to control the ingestion of marijuana and also has side effects related specifically to its carcinogenic potential and the link with respiratory diseases. The institute also found that the psychoactive effects of marijuana are sometimes, but not always, beneficial for some patients. Finally, the institute pointed out that smoking marijuana should not be recommended over the long term because of the potential mental effects, but could be prescribed for persons with terminal or degenerative diseases, where long-term considerations are secondary. In the Netherlands, the National Health Council issued a notice in 1995 stating that scientific evidence on medical use of marijuana was insufficient because of poor research and uncertainty as to the properties of smoked marijuana. The council also noted that marijuana could have therapeutic applications in the following areas: nausea and vomiting related to chemotherapy, appetite stimulation for people with AIDS or cancer, multiple sclerosis and glaucoma. In 2001, the Netherlands created a medical marijuana bureau in the ministry of health and began clinical studies. In England, the House of Lords has taken a position similar to that of the Institute of Medicine in the United States, and the Ministry of Health is currently conducting at least one clinical study.

Clearly, **not enough is known about marijuana to establish it as a drug in the strict sense of the word, and we only have partial knowledge of cannabinoids**. Most cannabinoids are a single cannabinoid compound, whereas marijuana contains many substances the effects of which interact to produce the therapeutic effects. Yet researchers have still not specifically identified the role of the various cannabinoids. Patients who use synthetic dronabinol or nabilone-based compounds generally report not feeling the same beneficial effects as when they smoke marijuana. It may take longer for the effects to be felt, and the effects may be less specific. Further, isolating only one of the components of marijuana could, according to some studies, increase the risk of panic attacks and even marijuana-induced psychosis.

> *A significant benefit of whole marijuana is that it can be delivered in smoked format, with a rapid onset of action and a tritable effect by the patient. [...] In practice, both patients and oncologists report that smoked marijuana is somewhat more effective than and as safe as the legally available oral cannabinoids. Another major difference between marijuana and THC, besides the availability of a smokeable, titratable delivery system with whole marijuana, is that 9-THC alone can produce the relatively common effects of anxiety disorder and panic attack. [...] The adverse effects can also occur with marijuana use,*

but are felt to be diminished by the presence of cannabidiol, a nonpsychoactive compound with antipsychotic properties. [21]

Finally, the cost of synthetic compounds, which is much higher, has to be taken into account.

The advantages of smoked marijuana are that patients can determine the necessary dose on their own and feel the effects more quickly, while limiting the adverse side effects other than the effect on the respiratory system. It should be noted in passing the importance of self-regulation by patients: most of the clinical cases reported and most of the testimony from compassion club representatives agree that patients prefer to use marijuana with a higher THC content than recreational marijuana but only ingest the quantity they need to achieve the calming effects. However, the problems related to specific knowledge of the effectiveness and quality of marijuana limit the ability of physicians to prescribe the appropriate dose. More advanced knowledge of smoked marijuana pertains to the degree of safety, although there is variation in interpretation of the data. We generally concur in the finding of Professor Scholten:

Cannabis use for medicinal reasons by patients with a somatic disease is relatively safe, on condition that it is not smoked; when smoked it has the same carcinogenic potential as tobacco. The alternatives are oral administration or inhalation using a vaporiser.
The acute toxicity of cannabis is very low; it is almost impossible to die of an overdose (users would have to eat or smoke their own weight in fresh cannabis, or 7,500 grams of dried cannabis to achieve this).
The principal side effects in therapeutic use are psychosis and euphoria. Little is known about this drug's addictive effect in medical use, though experience with the use of morphine for pain relief has shown that the risk of psychological addiction is low – much lower than when used as a stimulant. As the addictive effect of cannabis is also quite low when used as a stimulant, it may be assumed that this will always be very low in a medical setting.
When estimating the chronic toxicity of cannabis, it should be borne in mind that the doses used in therapeutic applications will probably be lower than those used for "recreational" purposes, decreasing the risks of side effects. [22]

Does this mean that medical use of marijuana, smoking in particular, should be discouraged or even banned? The last section addresses this question.

CURRENT THERAPEUTIC PRACTICES

---

[21] Gurley, R.J., R. Aronow and M. Katz (1998), "Medicinal marijuana: A comprehensive review", *Journal of Psychoactive Drugs*. Vol. 30, No. 2, page 139.

[22] Scholten, W.K. (2002), "Medicinal cannabis: A quick scan on the therapeutic use of cannabis", in Pelc, I. (ed.), *International Scientific Conference on Cannabis*, Brussels.

The main reservations about therapeutic use relate to the lack of comprehensive knowledge based on controlled medical studies and also to the long-term impact on the respiratory system and carcinogenic potential. In some cases, reservations have been expressed regarding the psychoactive properties of marijuana. There is a growing consensus on the therapeutic potential of marijuana, particularly smoked marijuana. While marijuana cannot, strictly speaking, be considered a drug, at least for the time being, it still has therapeutic properties. How then do we classify and regulate it?

Canada, the United States and many other countries have developed a parallel practice of allowing people with certain conditions to use marijuana. The most familiar example in Canada is without question the Vancouver Compassion Club.

In its mission statement, the club advocates a holistic approach to health. It not only supplies marijuana, but also delivers other forms of natural medicine (herbal therapy, acupuncture, massage, etc.). The club is built on the values of compassion, emancipation and complementarity between approaches.

In the six years since the Compassion Club was founded, an intimate knowledge of the therapeutic effects of marijuana has been acquired. The club offers a daily menu comprising seven to ten varieties of marijuana, one or two varieties of hashish, cannabis tincture, and baked goods containing marijuana. It sells marijuana for $3 to $10 a gram, depending on the variety. It currently serves more than 2,000 members/clients.

> *Our members have a huge range of symptoms and conditions such as HIV and AIDS, cancer, multiple sclerosis, arthritis, chronic pain, fybromyalgia, seizure disorders, glaucoma, hepatitis C, anxiety, depression, insomnia, eating disorders and many others. [...]*
>
> *It is important that medicinal users have access to a variety of strains, as the effect of cannabis varies depending on which strain is being used and the method of ingestion. Our members are made aware of the differences and can then select the best strain of cannabis to most effectively treat their symptoms.*
>
> *Indica and sativa are the two main varieties of the cannabis plant used as medicine. Many strains are crosses of those two varieties. Within each of those varieties and crosses there are a huge number of individual strains, each with a different cannabinoid profile and effect.*
>
> *According to the anecdotal evidence, the indica strains are a relaxant, effective for anxiety, pain, nausea, appetite stimulation, sleep, muscle spasms and tremors, among other symptoms. The sativa strains are more of a stimulant, effective in appetite stimulation, relieving depression, migraines, pain and nausea. We are now aware of specific strains that are effective for specific conditions and symptoms. Members keep track of their use in order to find the most effective strain for themselves. We also keep close records monitoring members' purchases in order to assist members to track their own consumption and for us to prevent reselling and to encourage responsible use.* [23]

[23] Hilary Black, Director, Vancouver Compassion Club, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, November 7, 2001, Issue 10, page 36.

Having read that testimony and the documents given to us by the club, visited the club's premises and examined its records, and heard the testimony of other people who work for similar organizations in Montreal and Toronto, we can safely say that there are links between this therapeutic practice and the data produced by research on medical uses of marijuana.

We also observe that this organization, like others that provide a similar service in Canada, keeps detailed records of their clients and their marijuana use; these records allow treatment to be monitored, but could also be excellent material for empirical research. **We can only lament the fact that Health Canada has not undertaken clinical research in cooperation with this organization** We share the reservations voiced by Hilary Black regarding the traditional protocols used in research on therapeutic use of marijuana:

> *We created a research proposal with a team of research scientists from Vancouver. However, we were turned down because we refuse to facilitate a study using a placebo or low-quality, low-potency cannabis imported from the US National Institute on Drug Abuse. Any study attempting to prove the effiacy of cannabis as a medicine using such a low-potency herb, or unknown strains such as those currently being grown in Canada by Plant Prairie Systems, is destined to fail. There is no need to import cannabis for research, considering the high quality and huge quantity of cannabis being produced in Canada. The information we could gather is being requested by doctors, patients, pharmaceutical companies, Plant Prairie Systems and Health Canada, yet we are not financially empowered to facilitate this research.* [24]

No one will deny that research on therapeutic uses of marijuana, whether smoked or synthetic, must continue in an effort to further clarify the key elements of quality, effectiveness and safety. Everyone agrees that we should learn more about the strains and doses appropriate to various conditions. For all that, do we have to think of marijuana as a drug like the other drugs listed in the pharmacopoeia? Do we have to have the same requirements as those applicable to prescribed drugs, or should we relax the rules to view marijuana a natural health product? Were it not for the legal system and the international conventions governing marijuana, would the plant not be considered more a natural health product like other plants and herbs?

Casting the issue in those terms forces us to think differently about the therapeutic use of marijuana. If the aim is to make it a approved therapeutic product, the reservations of the medical profession, or at least of some representatives of the profession, are understandable: they cannot endorse the approach until the proper controlled studies are carried out so that physicians can prescribe marijuana as confidently as they prescribe other approved therapeutic products. If marijuana is recognized as having therapeutic uses in some cases – at least as proven as any other plant used in homeopathy or herbal therapy – the aim is instead to give it the same status as other natural health products.

---

[24] *Ibid.*, page 39.

CONCLUSIONS

The Committee is of the opinion that the potential therapeutic uses of marijuana have been **sufficiently documented to permit its use for therapeutic purposes**. It should be acknowledged that smoking marijuana can have harmful side effects, particularly for the respiratory system, and users should be informed accordingly. It should also be acknowledged that research is needed to further clarify the specific field of marijuana use and the long-term effects of marijuana.

Conclusions of Chapter 9	
Therapeutic applications	➢ **There are clear, though non-definitive indications of the therapeutic benefits of marijuana in the following conditions: analgesic for chronic pain, antispasm for multiple sclerosis, anticonvulsive for epilepsy, antiemetic for chemotherapy and appetite stimulant for cachexia.** ➢ **There are less clear indications regarding the effect of marijuana on glaucoma and other medical conditions.**
Marijuana as a drug	➢ **Marijuana has not been established as a drug through rigorous, controlled studies.** ➢ **The quality and effectiveness of marijuana, primarily smoked marijuana, have not been determined in clinical studies.**
Marijuana and synthetic compounds	➢ **There have been some studies of synthetic compounds, but the knowledge base is still too small to determine effectiveness and safety.** ➢ **Generally, the effects of smoked marijuana are more specific and occur faster than the effects of synthetic compounds.** ➢ **The absence of certain cannabinoids in synthetic compounds can lead to harmful side effects, such as panic attacks and cannabinoid psychoses.** ➢ **Smoked marijuana is potentially harmful to the respiratory system.** ➢ **People who smoke marijuana for therapeutic purposes self-regulate their use depending on**

	their physical condition and do not really seek the psychoactive effect ➢ People who smoke marijuana for therapeutic purposes prefer to have a choice as to methods of use.
Therapeutic practices	➢ Measures should be taken to support and encourage the development of alternative practices, such as the establishment of compassion clubs. ➢ The practices of these organizations are in line with the therapeutic indications arising from clinical studies and meet the strict rules on quality and safety
Research	➢ The studies that have already been approved by Health Canada must be conducted as quickly as possible. ➢ The qualities of the marijuana used in those studies must meet the standards of current practice in compassion clubs, not NIDA standards. ➢ The studies should focus on applications and the specific doses for various medical conditions. ➢ Health Canada should, at the earliest possible opportunity, undertake a clinical study in cooperation with Canadian compassion clubs.

CHAPTER 10

CANADIANS' OPINIONS AND ATTITUDES

One of our main objectives throughout our study was to get Canadians involved. We wanted people to share their opinions, experiences and fears regarding marijuana. We also wanted to provide access to the information we held so as to contribute, within our modest means, to better knowledge of the realities of marijuana, if only to raise the level of public debate. At the start of each public hearing the Committee Chair stated:

> *The second thrust is the sharing of knowledge. This is definitely our most noble objective. The committee wants all Canadians to become informed and share the information we collect. Our challenge will be to plan and organize a system to ensure that the knowledge is available and distributed. We would also like to hear what people think about this knowledge. In order to do this, in the spring of 2002, we will be holding public hearings in various parts of Canada.*

This was indeed a major challenge. It is one thing to passively make available such information as proceedings of our hearings and our commissioned research reports. It is another thing to actively disseminate that information widely, having the means to do so. And it is another thing again to take the pulse of Canadian society.

To convey the information to Canadians, we chose to make full use of our Internet site, posting all of our documents as they were ready. To boost circulation, we used two main tools. The first was a conventional tool: the media. We worked to get as much media coverage as possible in order to promote our work or simply let people know the Committee existed. With the same goal in mind, some members of the Committee took part in conferences, round table discussions and open-line shows. The second tool, one we considered essential in promoting our work, was the discussion paper we released in May 2002. The paper laid out some of our preliminary research findings on eight key issues, put forward a number of public policy options and proposed questions for the public hearings. The main aims of the paper were to convey our knowledge and generate public interest. A third objective was to provide a backdrop for the public hearings we held throughout the country in May and June 2002.

Only time will tell whether and to what extent we were successful in promoting our work and, more importantly, in increasing public knowledge of marijuana. We did not have the financial means to conduct a far-reaching public information campaign or

an opinion poll before and after the release of the discussion paper to determine whether we had any impact on Canadians.

It is much harder to gauge the public's opinions, attitudes and concerns. The traditional method of surveying a representative sample of the population was too expensive. Surveys also have limits, which we will discuss in more detail later. However, we did commission a qualitative study using focus groups, the results of which will be presented in this chapter. We will also report the results of other surveys that came to our attention. As well, many Canadians wrote to us or sent us e-mails, and some came out to our public hearings. We obviously cannot draw any conclusions from this: the only people who wrote to us were probably people to whom the issue is very important, regardless of which way they lean. Some will be cited but we reiterate that nothing is to be drawn from these opinions in terms of representativeness.

No account of Canadians' opinions on and attitudes toward drugs in general would be complete without an examination of the role of the media in shaping those opinions and attitudes. In recent years, as a result of this Committee's work and other initiatives, various Canadian newspapers and magazines have run stories or written editorials on the issue. These will be the focus of the first part of the chapter. The next part presents the results of surveys and polls, including the survey we commissioned and surveys conducted in different provinces. The last part covers our understanding of what Canadians told us.

THE MEDIA

At the start of the century, the media played a key role in creating a moral "panic" over illegal drugs. First it was the "Yellow Peril" and the opium crisis in the early 20th century, primarily in Vancouver.[1]

> *[...] tolerance for the habit of smoking opium lasted only as long as British Columbia's tolerance for the Chinese. In the early years of the twentieth century, both a labour surplus and anti-Asian resentment developed [...] If you look at the Vancouver Province, virtually any front page in the first five years of the 20th century, there are racist cartoons warning about the yellow peril, about how British Columbia is going to be swallowed up by the Chinese, and about another boatload arriving.*[2]

[1] See the analyses by Giffen, P.J., *et al.* (1991), *Panic and Indifference. The Politics of Canada's Drug Laws*, Ottawa: Canadian Centre on Substance Abuse; Boyd, N. (1991), *High Society: Illegal and Legal Drugs in Canada*, Toronto: Key Porter Books.

[2] Boyd, N., *op. cit.*, pages 27-29.

The following appeared in *Canadian Magazine* in 1900:

> *It was quite evident he (the Chinese servant) had had his share and a night of it, for there are Chinese dens in Vancouver where opium is smoked and unspeakable infamies are practised, and no matter how meek and mild your Chinaman may look, no matter how gentle his voice or confiding his manner, Saturday night is almost certain to find him 'doped' in his bunk, weaving dreams under the poppy's subtle spell.* [3]

Then it was the cocaine plague in Montreal as described by the following article in the Montreal *Witness* in 1910:

> *This curse of cocaine [...] has existed for a short time in the city. It is a real evil. It is a social plague, and it goes on spreading so fearfully that it is time for society to take marked notice. Alcoholism and morphia are nothing to cocaine. It is the agent for the seduction of our daughters and the demoralization of our young men. [...] Those who know what cocaine is and what its evils are, are those who can hurt society most.* [4]

This vision of the decay and degeneration of the working class and, more broadly, Anglo-British and Christian civilization, would subsequently be picked up by temperance movements. A key figure in women's history in Canada, Emily Murphy, would play a leading role in the 1920s in articulating this apocalyptic vision. Murphy, a writer and journalist, was president of the Canadian Women's Press Club (1913-1920), the founding president of the Federated Women's Institute and a member of the National Council of Women of Canada before becoming a judge in Alberta. She also fought to have women's rights recognized in the Canadian constitution. She was a tireless fighter in the war on drugs. In a series of articles published in *MacLean's* magazine in 1920, she attacked the "plague" of drugs.

> *[...] whatever form these drugs are taken, they degrade the morals and enfeeble the will. No matter what their status has been, inveterate users of drugs become degraded. All are liars: nearly all become dishonest. Being deprived of the drug, they will go any length to get it, even to thievery and prostitution. While sober they are uncomfortable, and prolonged abstemiousness hurts them like nails driven into the flesh.* [5]

---

[3] Quoted in Giffen, P.J., *op. cit.*, page 61.

[4] Quoted by McKenzie King in Hansard, House of Commons, January 26, 1911, pages 2641-2642.

[5] Murphy, E., (1920), "The underground system", *MacLean's*, March 15, 1920.

In 1922, in her book *The Black Candle*, she also attacked marijuana, which she described as follows:

> *Persons using this narcotic smoke the dried leaves of the plant, which has the effect of driving them completely insane. The addict loses all sense of moral responsibility. Addicts to this drug, while under its influence, are immune to pain, and could severely injured without having any realization of their condition. While in this condition they become raving maniacs and liable to kill or indulge in any form of violence to other persons, using the most savage methods of cruelty without, as said before, any sense of moral responsibility. When coming under the influence of this narcotic, these victims present the most horrible condition imaginable. They are dispossessed of their natural and normal will power and their mental is that of idiots. If the drug is indulged in any great extent, it ends in the untimely death of the addict.* [6]

Beyond the verbal impact of these articles and racism toward Asians, there is some similarity between the messages being conveyed at that time and some contemporary messages about drugs: drugs attack the moral roots of society, the family in particular. They put young people at risk and cause crime and violence. Dealers are everywhere, especially around schools, ready to do whatever it takes to expand their client base. And drugs, by definition, lead to drug addiction.

That does not mean, of course, that the newspaper articles were the main reason why drugs were criminalized. Nor does it mean that people ultimately believed what was written. Still, analysts of the evolution of drug laws in Canada agree that the media played an important role in shaping Canadian drug legislation.

Where do Canadian media stand on drugs today? We did not analyse all the press coverage of drugs in Canada, although the exercise would probably have been interesting in sociological terms in identifying key notions and seeing just how public opinion is shaped. All we do here is examine two main types of media article. The first is news related to criminality, the second, feature stories and editorials.

News stories on illegal drugs usually focus on police operations: raids, seizures, dealer arrests and dismantling of organized crime rings. The best-known modern example was surely the 2001 arrest in Quebec of more than 70 Hells Angels members known to be involved in narcotics trafficking and other illegal activities. And then there are seizures, month after month, of kilograms – even hundreds of kilograms – of drugs, more and more often marijuana.

We do not know how this information helps shape public opinion on drugs or what impact it has on the public's demands concerning drugs. However, these articles probably give people the impression that the "drug problem" is first and foremost an organized crime problem. But while there may have been an impression until the mid 1980s, shall we say, that marijuana was a problem exported into Canada from other countries, the growing number of articles on raids of domestic producers – as opposed

[6] Murphy, E., (1922) *The Black Candle.* Toronto: Thomas Allans, pages 332-333.

to shipments from overseas – is giving more and more people cause to think of marijuana as a home-grown problem.

Other news stories focus on the relationship between drugs and crime, especially prostitution, residential break-ins, and "incivilities" experienced by street youth and the homeless. Some of these activities are at least in part associated with drugs. For prostitution, it is the fact that people, mostly women, are forced to work as street prostitutes in order to support their habit. Residential break-ins are also tied to supporting drug habits, although the perpetrators are different: most break-ins are committed by young men. For street youth, the main problem is intravenous drug use and the risk of spreading AIDS. None of this is directly related to marijuana. Except for schools. Virtually every big city in Canada – and every not-so-big city, too, for that matter – has seen some kind of police operation in schools. School raids usually elicit two types of reaction, both rooted in indignation: people are indignant when they learn that drugs are so much a part of the school environment while others think the police are abusing their authority and failing to respect young people's rights.

Several years ago, there were a number of feature reports in newspapers and the electronic media. The series written by journalist Dan Gardner of the *Ottawa Citizen* in 2000, which was picked up by most of the newspapers in the Southam chain, is surely the best-known example. In his 10-article series, Gardner explained why the "war on drugs" is a patent failure. He began his series as follows:

> *Uncle Sam's global campaign to end drug abuse has empowered criminals, corrupted governments and eroded liberty, but still there are more drug addicts than ever before. On June 6, 1998, a surprising letter was delivered to Kofi Annan, secretary general of the United Nations. 'We believe' the letter declared, 'that the global war on drugs is now causing more harm than drug abuse itself. The letter was signed by statesmen, politicians, academics and other public figures. Former UN secretary general Javier Perez de Cuellar signed. So did George Shultz, the former American secretary of state, and Joycelyn Elders, the former American Surgeon General. Nobel laureates such as Milton Friedman and Argentina's Adolfo Perez Esquivel added their names. Four former presidents and seven former cabinet ministers from Latin American countries signed. And several eminent Canadians were among the signatories. The drug policies the world has been following for decades are a destructive failure they said. Trying to stamp out drug abuse by banning drugs has only created an illegal industry worth $400 billion US. 'or roughly eight per cent of international trade.' […] This powerful statement landed on Mr. Annan's desk just as the United Nations was holding a special assembly on global drug problems. Going into that meeting, the governments of the world appeared all but unanimous in the belief that the best way to combat drug abuse was to ban the production, sale or possession of certain drugs. […] Still, the letter to Mr. Annan showed that this view is far from unanimous. In fact, a large and growing number of world leaders and experts think the war on drugs is nothing less than a humanitarian disaster.*[7]

[7] Gardner, D., "Why the war on drug has failed: Uncle Sam's war", *Ottawa Citizen*, September 5, 2000.

In a way, Gardner's series echoed editorials that ran in the *Ottawa Citizen* in 1997 calling for the decriminalization of drugs.[8] The following appeared in the second article in the series: *"The recent history of drug enforcement, in both Canada and the United States, is largely a record of failure. Tax dollars are lavished on enforcement. Police powers are expanded at the expense of civil liberties. Criminal gangs grow richer. And drug use goes on regardless."*

In 1998, the Toronto *Globe and Mail* expressed a similar view under the headline "*What are G8 Leaders Smoking?*" The newspaper wrote, *"Prohibition does not work and cannot work, and its costs are higher than those of a policy of properly supervised and regulated access to drugs. Given that the elimination of drugs from our society is not an option, the G8 leaders should have been asking themselves how they can minimize the harm that drugs represent. As it is, their policies maximize the damage."* The *Globe and Mail* did the same thing in a two-part editorial in July 2001, recommending decriminalization of marijuana. The *Vancouver Sun* followed suit in October 1998, and the *National Post* also called for an end to the prohibition on marijuana. More recently still, in the wake of the tragic events of September 11, 2001, the *Citizen* editorial staff responded to those who suggested that money fom drug trafficking was being used to finance terrorism. The editorial read:

> *The latest drug-war scare, from Solicitor General Lawrence MacAulay and others, is that terrorists may be using drug money to finance their evil deeds. If so, you can see why. Terrorism, like any real crime, produces victims rather than satisfied customers, so it's not exactly self-financing. The drug trade, by contrast, turns a regular profit because it involves transactions so mutually satisfactory that buyers and sellers will risk jail to conduct them. [...] In short, the drug war not only brings the law into contempt and threatens public safety, it also funnels money to terrorists and helps them move between countries. And people want more of it? I say a virtuous choice must be a choice to be virtuous, so I'd repeal the drug laws on moral grounds. But put aside my distaste for paternalism. If fighting the war on drugs increases the danger of losing the war on terror, surely it's doing far more harm than good.* [9]

These editorials and features are interesting for many different reasons. First, they mark a major shift from the positions that were more tentative or simply favoured prohibition that had held sway since the beginning of the century. They were also part of a constant questioning of the government's role and the appropriateness of government spending and reflected growing concern for individual freedoms.

We do not know how they affect public opinion. We are not in a position to say if they reflect views held widely among the public or whether they are skewed. Only one thing strikes us as relatively certain: most major media outlets in Canada have distanced themselves quite significantly from prohibitionist policies.

---

[8] Editorial, "Decriminalizing Drugs", *Ottawa Citizen*, April 12, 1997, April 14, 1997, April 15, 1997, and April 16, 1997.

[9] John Robson, "How many burbs must the drug war burn, before we call it a bust?, *Ottawa Citizen*, May 17, 2002.

SURVEYS

According to one of our witnesses:

From public opinion data assembled over the last 10 years, some by Health Canada, we know that more than two thirds of Canadians think that no one should go to jail for cannabis use, and approximately half of Canadians explicitly advocate the decriminalization or depenalization of cannabis use. This has been consistently the case over the last 25 years. In other words, there has been a public opinion message for a quarter of a century that so far has been ignored by lawmakers and policy-makers. [10]

One of the biggest limitations of opinion polls is their superficial nature: the questions are often inserted into more general surveys covering a variety of subjects, there is little opportunity to ask multiple questions, and the meaning of the terms is rarely explored. For example, the terms "legalization" and "decriminalization" do not necessarily mean the same thing to all respondents. But general surveys are not able or rarely have the means to bring those differences to light. If the survey asks a single question about marijuana along the lines of "are you in favour of decriminalizing the possession of small quantities of marijuana?", there is no way of knowing what the respondents think when they hear "decriminalizing" and "small quantities". For some, decriminalization may mean no penalty; for others, it may mean a fine. And the difference between 5 grams and 30 grams is enormous.

Like the media, and in an equally complex way, surveys help shape public views. And also like the media, it is hard to determine the role they play in changing attitudes and, more importantly, behaviour. With those reservations out of the way, we provide in the following paragraphs a sample of data from a number of different surveys.

In the 1994 national survey on alcohol and drugs, the respondents were asked to give their opinion on marijuana: 27% said that possession of small quantities should be legal; 42% said it should be illegal but should not result in a penalty or should result in a fine only; and 17% said that possession of marijuana should lead to a possible prison sentence for a first offence. Men and younger people are more inclined to favour legalization of marijuana, as are residents of British Columbia, Quebec, Alberta and Ontario.[11]

In 2000, the *National Post* reported the results of a survey which showed that almost two thirds of Canadians were in favour of decriminalizing marijuana and that the punishment for possession of small quantities for personal use should be a fine.[12]

---

[10] Dr. Benedikt Fischer, Professor, Department of Public Health Sciences, University of Toronto, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session of the thirty-seventh Parliament, September 17, 2001, Issue 6, page 13.

[11] Canadian Centre on Substance Abuse (1999), *Canadian Profile, 1999: Alcohol, tobacco and other drugs*, Ottawa: author, pages 214-215.

[12] National Post, "Two-thirds favour decriminalizing pot", May 15, 2000.

More recently still, in a May 2001 survey, 47% of Canadians said they favour legalization of marijuana, up from 31% in 1995 and 26% in 1975.[13]

A smaller survey of public perceptions was conducted in Quebec in 2001 using a sample of 2,253 respondents (response rate 70%).[14] The survey focused solely on drugs, drug addiction and HIV and measured knowledge, perception of risk, perception of drug addicts, and possible policies and measures. What makes this type of study interesting is that because the questions were limited to drug addiction and drugs, it provides clearer and more comprehensive information on certain issues.

The study showed that the majority (66%) of Quebeckers think that drug use is increasing. It also showed that "[translation] *marijuana is in a class of its own*" in terms of perception of risk because "[translation] *only one in four people felt that marijuana is dangerous the first time it is used, which is less than the opinion reported for tobacco, even though tobacco is legal. Moreover, marijuana is the only substance that a relatively large number of respondents described as never harmful to health. [...] People consider it less dangerous than tobacco.*"[15] The surveys also show that marijuana is the substance least likely to lead to addiction: approximately 15% of respondents think that marijuana creates a dependency the first time it is tried, whereas more than 40% said it would have to be used every day and 8% said that marijuana never creates dependency.[16]

As to opinions on public policy, the study showed a clear preference for prevention and education over controls and repressive measures. Almost 35% of those asked what measures would be likely to eliminate drug problems said that the controlled sale of marijuana and hashish would help reduce the adverse effects. According to the authors, the public "[translation] *is very open to some form of legalization of hashish and marijuana. More than 90% said that people with certain serious illnesses should be allowed to get prescription hashish and marijuana in order to relieve their pain. Far fewer people, although still a majority (60%), would be willing to allow those drugs to be used under certain conditions perhaps like alcohol.*"[17] Fewer than 40% thought that current laws help prevent people from using (and approximately 60% disagreed somewhat or completely with that statement).[18]

---

[13] Julian Beltrame, "Reefer Madness: The Sequel", *MacLean's*, August 6, 2001, Vol. 114, pages 22-25.

[14] Hamel, D., *et al.* (2001), *Perceptions de la population québécoise en lien avec les programmes de prévention de la toxicomanie et du VIH*, [public perceptions in Quebec regarding substance abuse and HIV prevention programs], Quebec City: Institut national de santé publique du Québec.

[15] *Ibid.*, page 3.

[16] *Ibid.*, page 27.

[17] *Ibid.*, page 4

[18] *Ibid.*, page 38.

In Ontario, the school survey also looked at students' perception of risk and disapproval of marijuana use. The results are shown in the following table.

Perceptions of Ontario high-school students, 1989-2001 [19]

	1989	1991	1993	1995	1997	1999	2001
Disapprove of experimentation							
Total	40.8%	43.2%	37.1%	28.8%	23.4%	26.0%	28.6%
Grade 7	58.9%	58.0%	48.6%	44.9%	40.8%	44.3%	48.2%
Grade 9	38.0%	48.3%	38.8%	30.1%	21.6%	25.7%	23.7%
Grade 11	33.0%	32.5%	30.2%	16.3%	13.2%	18.2%	19.4%
Grade 13	26.7%	28.4%	27.7%	25.7%	18.8%	13.4%	20.7%
Disapprove of regular use							
Total	61.0%	60.8%	55.9%	47.2%	45.2%	43.1%	41.7%
Grade 7	73.7%	72.1%	66.6%	62.3%	58.7%	63.6%	64.0%
Grade 9	59.8%	62.5%	54.3%	48.6%	41.1%	43.6%	34.3%
Grade 11	54.9%	52.4%	50.9%	33.6%	30.9%	31.2%	29.8%
Grade 13	50.1%	56.1%	51.1%	48.6%	42.6%	32.8%	40.7%
Associate high risk with experimentation							
Total	27.8%	30.7%	27.3%	18.5%	17.1%	18.4%	18.6%
Grade 7	39.2%	37.0%	35.3%	30.7%	26.2%	28.4%	27.0%
Grade 9	29.7%	35.4%	29.3%	18.6%	14.3%	16.6%	18.5%
Grade 11	18.0%	25.2%	21.8%	10.5%	12.8%	15.2%	11.1%
Grade 13	19.2%	21.2%	19.7%	14.2%	16.4%	12.5%	17.7%
Associate high risk with regular use							
Total	75.4%	73.3%	69.3%	58.1%	56.1%	52.0%	48.2%
Grade 7	72.6%	72.1%	69.8%	67.6%	60.5%	63.6%	61.1%
Grade 9	79.1%	74.0%	73.7%	60.8%	59.3%	53.1%	47.8%
Grade 11	74.7%	73.9%	66.9%	50.8%	49.4%	44.9%	36.8%
Grade 13	73.3%	73.1%	63.4%	50.6%	55.7%	45.2%	47.8%

These results show that Ontario high-school students' attitudes on all indicators are either less alarmist or more liberal, depending on one's point of view. Fewer students disapproved of experimentation (one or two times) with marijuana and regular use in 2001 than in 1989. However, more students still disapproved of regular use than occasional use. The level of disapproval decreases as level of schooling increases. Further, fewer Ontario students associated a high risk with marijuana use in 2001 than in 1989, but still almost three times as many associated a high risk with regular use than with experimentation. It bears noting that students who associate a high risk with

[19] Adlaf, E.M., and A. Paglia (2001), *Drug Use among Ontario Students 1977-2001. Findings from the OSDUS*, Toronto: Centre for Addiction and Mental Health.

regular marijuana use now make up less than half the student population, down from three quarters in 1989.

By and large, these data are in line with the results of the study the Committee commissioned from the firm Léger Marketing.[20] The objective of this qualitative study using focus groups was to determine whether it was possible to identify elements that could serve as the basis of a social consensus on the use of cannabis. More specifically, the study was designed to determine the overall perception of drug use in general and cannabis in particular; the images associated with cannabis; attitudes and social behaviour toward the use of cannabis for recreational purposes; fears and prejudices; knowledge of the legislative framework; and the expectations of citizens with regard to a public policy on the use of cannabis for recreational purposes. Léger held 16 focus groups and conducted 15 in-depth interviews in Montreal, Trois-Rivières, Halifax, Winnipeg, Vancouver, Toronto and London. In all, more than 130 people took part in the study. In each city, there were at least two focus groups, one with adults over the age of 18, and one with youth 14 to 17 years of age.

The participants in the focus groups did not spontaneously mention drugs as everyday concerns; they reported being more concerned about health, education, employment and poverty. When the subject was raised by the interviewers, the participants first named crime related to the sale of drugs and drug smuggling as primary concerns, not drug use by Canadians. In some cities (Montreal, Vancouver), the participants also voiced concern about the impact illegal drugs have on quality of life and safety in some neighbourhoods.

Questioned about marijuana, almost all of the participants spontaneously made a distinction between soft drugs (marijuana, hashish) and hard drugs (cocaine, heroin); some even thought the word "drug" was inappropriate in reference to marijuana. That distinction is based on two major elements: composition and effect. Hard drugs are more closely associated with chemical products that have destructive effects, particularly a greater tendency to develop an addiction. Marijuana and marijuana derivatives are associated with plants or natural products, and the risk of dependency is virtually nil, except among people who are especially predisposed or vulnerable. There were many comparisons with alcohol: alcohol can be used in reasonable quantities without a problem, and only a small proportion of users develop dependency problems. Nor was marijuana associated with crime: *"I can't picture a guy robbing the corner store to buy himself a joint. This is something heroin addicts would do. First, pot is cheap, second it doesn't make you want it desperately."* The only exception more common in Quebec than elsewhere was the association with organized crime, that is, motorcycle gangs.

In contrast to "hard" drugs, which are considered part of a world of moral and physical distress and social decay, the participants generally associated marijuana with relaxation and pleasure, a drug used primarily in social settings, like alcohol.

[20] Léger Marketing (2002), *An Exploratory Study Among Canadians About the Use of Cannabis*, Montreal: author. Available on line at the Committee's site.

In any event, recreational use of marijuana was generally well accepted: *"it doesn't bother me that people do marijuana. As long as they are aware of their decision and what they are doing, I respect it."* In fact, several participants in each group spontaneously mentioned their own past or current experiences with marijuana use: *"I sometimes smoke pot and it doesn't keep me from being a productive guy at work or a good family man."* And like alcohol, the difference lay more in the notions of abuse and responsibility, although the participants were harder on alcohol abuse, which they associate with violence. *"I used to go out to bars a lot. Every night there would be a fight. A guy gets drunk and then starts insulting somebody else or feels another is flirting with his girlfriend. At one point punches get thrown around. But you know what? I have never seen a guy stoned on pot go nuts and want to knock somebody out."* While they did not associate marijuana use with violence or crime, the participants did express concern about people's behaviour when under the influence of marijuana. Finally, the participants did not associate marijuana use with a particular social class: young people use marijuana, but so, too, do professionals, artists, lawyers, government employees and others.

The researchers did not observe any generational differences in recreational use of marijuana. If there were a difference, it would be rooted more in socio-occupational features: people with less education and people in rural areas appear to be more resistant. Further, people who oppose recreational use of marijuana do so more for moral and sometimes even religious reasons. Another difference is that women with school-age children said they were very concerned about how readily available marijuana is in schools. [translation] *"I don't care if they legalize it or not. All I want is for marijuana to be kept away from children. It makes me furious that they sell it in primary school, because that gets them hooked at a very young age."*

As the public opinion surveys discussed earlier showed, the participants generally supported the legalization of marijuana for medical use. However, some of the respondents said they would like to see a clear distribution structure put in place in health care establishments and that dosages should be geared to the intensity of the pain.

Generally, the participants felt that occasional use had no adverse health effect. Spontaneously making a comparison with alcohol and tobacco, they felt that marijuana was not the most dangerous of the three substances. Further, most of the respondents were not afraid of people getting hooked on marijuana, noting that dependency is a function of the person's maturity and frequency of use. *"This is the key question. I don't think you can get hooked on it really. Not as much as booze or nicotine for sure. But that's the kind of proof or medical evidence I would like to have if you want me to make up my mind on it."* The participants also did not think that marijuana is a gateway to other drugs or "hard drugs", because the user's personality and maturity have more influence than the marijuana itself.

The interview guide asked the participants to react to two research findings: the proportion of Canadians who have used marijuana in the past 12 months is approximately 10%, and about 30,000 charges are laid a year for simple possession of

marijuana. In both cases, the participants were incredulous. Regarding the proportion of users, all the participants felt that there were far more: "[translation] *I'm surprised that only 10% of the population are users. I would have said 50% or 60%.*" Regarding the number of charges, the participants unanimously felt that police should focus more on fighting crime rings: *"30,000 people charged per year seems like a waste of taxpayers' money, if it is just for possession. It's a lot of money to prosecute and they all get thrown out anyway."* [translation] *"When you think about other, more serious crimes, when you think how it clogs up the courts, I think it's ridiculous."* Nevertheless, the participants felt that Canada is a relatively tolerant society when it comes to recreational use of marijuana, at least in comparison with other countries, and spontaneously named the United States and Saudi Arabia as repressive and Switzerland and the Netherlands as tolerant; Canada fell somewhere in between.

The interviews were conducted after the Committee released its discussion paper in which it set out a number of public policy options. The focus group participants were first urged to freely voice their opinions on the public policies they would prefer to see and were then presented with the Committee's proposals and asked to react.

By and large, the response from the participants fell somewhere between decriminalization and legalization. That position was most prevalent in Montreal, Toronto, Vancouver and Halifax; more participants in Vancouver and Montreal favoured legalization with government controls: *"The best option is decriminalization leaning towards government legalization. The worst option would be depenalization: to legalize without getting involved."* According to the participants, those options would make it possible to increase the ability to provide information about risk, user health, public safety, respect for individual rights and freedoms, and the effectiveness of government spending, and would reduce illegal trafficking and the involvement of organized crime. They also said they would anticipate an increase in recreational use of marijuana but did not think that there would necessarily be an increase in use or abuse among young people. On the contrary, several participants felt that decriminalization would lead to a decrease in use among young people because the appeal of the forbidden fruit would be gone.

There is still a hard-core minority who think that current laws are not harsh enough and that society should move toward greater criminalization of recreational use of marijuana. That position was voiced most loudly in Winnipeg among persons over 40 and in Trois-Rivières.

Finally, the participants said they would like to be informed and "educated" about marijuana use and in particular would like to be made aware of scientific knowledge of the short- and long-term effects, the real risk of dependency and escalation, ways of protecting children against early use, and the impact of decriminalization on the war on organized crime.

The authors of the study identified the following key factors:

- the protection of youth and children is central to any discussion of a public policy on marijuana;

- decriminalization of use is the preferred option, as it would make it possible to recognize the social reality and at the same time focus on the "real" problems;
- some participants expressed support for legalization but wondered about the nature and control of production and quality standards, methods of distribution and marketing, and the establishment of quotas in order to prevent abuse.

Because this was a qualitative survey, we cannot extrapolate the results to the entire Canadian population. Our financial resources did not allow us to conduct a comprehensive study using a representative sample of the population, which would have allowed us to validate these "hunches". Still, we are able to state the following: 1. these results are similar in many ways to the data from the opinion polls; and 2. the commonalities between the focus groups in most of the cities and between age groups suggest there is some validity to these hunches.

ATTITUDES AND OPINIONS SHARED WITH THE COMMITTEE

Hundreds of Canadians from all over the country wrote to us, and dozens appeared at our public hearings in the regions. They came to recount their personal experiences, state their opinions and voice their fears. They represented rights and freedoms advocacy groups, compassion clubs, which distribute medical marijuana, treatment and prevention organizations, and women's groups. They were mayors, police chiefs, users of medical marijuana, parents, educators, physicians, lawyers and recreational marijuana users, young and old alike. They often spoke from the heart, and we were moved by what they said. Appendix 2 is a list of all the people the Committee heard during its public hearings. We would like to thank all those who took part in our proceedings.

It is impossible to present in this report all the contributions to our discussions and highlight their extraordinary worth. Fortunately, the transcripts of the hearings will remain on our Internet site. The following will summarize the opinions conveyed to us in reaction to our discussion paper.

We should point out first of all that the people who shared their views were for the most part very happy with the diligence of our work and, more specifically, were very appreciative of the opportunity they were given to take part in this social debate.

> *I have followed with great interest the proceedings of the Special Committee on Illegal Drugs and would like to thank the person who decided to publish the brief so completely and honestly. This speaks volumes of transparent government, which is a key element in resolving the debate.*

I would first of like to commend the Senate for its Special Committee on Illegal Drugs and its impartial and ground-breaking work on marijuana.

Thank you for taking the time to review my submission. I would like to commend the Senate Committee on Illegal Drugs for its excellent research on the facts and criticism of the myths surrounding illegal drugs.

First of all, I would like to thank the Committee for skilfully separating the facts from the propaganda surrounding this issue. [...] Thank you for taking the time to get public input on the issue. I only hope that this will not fall on deaf ears as was the case with the Le Dain Commission before you. Again, I believe the Committee is trying to do its best for the people of Canada.

I read your discussion paper on marijuana and the accompanying documentation and found the material to be most interesting. I would like to commend you for your willingness to launch a public debate in this area of policy.

Most of the people who took the time to respond to us also said they found the discussion paper to be well done, useful and balanced. Moreover, the respondents said they agreed with the research data we presented in the paper. Where there were reservations, they pertained to:

- biased interpretation of the data: for some people, marijuana is unquestionably a gateway drug;
- an overly cautious side: saying that marijuana is a drug and therefore should not be used was perceived as "politically correct";
- a lack of compassion and concern for youth and children.

Many Canadians from different walks of life shared with us their concerns about the prospect of marijuana being decriminalized and about the message that that kind of decision would send to young people.

[Translation] *It doesn't make any sense to use to legalize a drug with all the question marks and solid facts that are seen as consequences of marijuana use. If we had to do it over again, I don't think with the information we currently have that we would want to legalize nicotine or even alcohol. Once we consider legalizing a drug, we can assume that the drug will become more readily available and that there will therefore be more use and more problems. Remember: marijuana is not harmful because it is illegal; marijuana is still illegal because it is harmful.* [21]

Informed public debate is healthy and valuable, but it requires exposure to a full range of viewpoints. Regrettably, this is not the case in regard to the non-medical use of drugs. Rather, we have had constant and copious representation of the view that the only way to deal with the drug problem is to accept its inevitability and even its normalcy. (...)

---

[21] Brief from A. Maillet and C. Cloutier-Vautour to the Special Senate Committee on Illegal Drugs, Moncton, June 5, 2002.

In discussion about drug strategies, the harm of illegal drugs is usually identified , not with the drug's intrinsic chemical effects on the human body, especially on brain function and behaviour, but rather on extrinsic consequences of the illegality of the drug. Thus, the general havoc wreaked on the lives of addicts and their families is ignored in favour of deploring the harm that a criminal record can do to self-esteem. Further, the property crime and violence carried out by drug users are attributed to the illegality of the drugs rather than to the diminished work habits and lack of earning capacity which result from drug use. [22]

Our concerns with the Discussion Paper released by the Committee centre primarily on cannabis policies and the resulting effects on youth and families. (…) We suggest to the Committee that rather than focusing on reforming our drug laws, efforts would be much better spent on examining strategies focused on prevention. (…) Much rhetoric exists around the supposed 'war on drugs': have we lost the war, what do we do now and were we really fighting a war to begin with? The challenge presented to this Committee is not an easy task: to recommend workable, feasible policies regarding cannabis use. To this end, we trust that the Committee will be prudent in its decisions, innovative in its policy recommendations and resistant to the urge to simply give sway to 'hemp mania'. We owe it to our young people. [23]

Please, ladies and gentlemen, please do not just rely on research and the experts. There are many well-financed documents and experts that are paid to promote legalization. THC, the active ingredient of cannabis can be taken in pills, we do not have to promote smoking in another form. […] If I could suggest the following: 1. Provide more treatment resources and services; 2. Change our system of incarceration when it comes to drug-induces crime – mandatory treatment; and 3. Have our country adopt a zero tolerance to illegal drugs and provide the ability to our police to enforce the policy and mandate our courts to address the issue. Please do not provide another avenue for our children to escape reality. [24]

That said, most of the people who responded to the questionnaire also said they were in favour of decriminalization or controlled legalization of marijuana and marijuana derivatives. For that reason, we have to be very careful still regarding the meaning of the comments we received: most of those who wrote to us are probably interested, for personal reasons, in seeing the current legislation amended to introduce more tolerance. That view probably coloured their assessment of our discussion paper and the quality of our research findings.

---

[22] Brief from Real Women, submitted to the Senate Special Committee on Illegal Drugs, June 6, 2002, pages 1-2.

[23] Brief from Focus on the Family to the Special Senate Committee on Illegal Drugs, Richmond, May 14, 2002.

[24] Letter from Kathy Bedard, Prince Rupert, British Columbia, May 15, 2002.

CONCLUSIONS

What is the status of public opinion in Canada? We are not able to come up with firm answers to that question. We do think, however, that:

Conclusions of Chapter 10	
Opinions on marijuana	➢ **Public opinion on marijuana more liberal than it was 10 years ago.** ➢ **Tendency to think that marijuana use is more widespread than it used to be.** ➢ **Tendency to think that marijuana is more available than it used to be.** ➢ **Tendency to think that marijuana is not a dangerous drug.** ➢ **Relatively significant concern about organized crime.** ➢ **Strong support for medical use of marijuana.**
Opinions on public policy options	➢ **Tendency to favour decriminalization or, to a lesser degree, legalization.** ➢ **Critical attitude toward law enforcement for simple possession of marijuana.** ➢ **Concern for youth and children.**

Sénat Senate

CANADA

LE CANNABIS :

POSITIONS POUR UN RÉGIME DE POLITIQUE PUBLIQUE POUR LE CANADA

RAPPORT DU COMITÉ SPÉCIAL DU SÉNAT SUR LES DROGUES ILLICITES

VOLUME I : PARTIES I ET II

PRÉSIDENT

PIERRE CLAUDE NOLIN

VICE-PRÉSIDENT

COLIN KENNY

SEPTEMBRE 2002

ORDRE DE RENVOI

Extrait des Journaux du Sénat du 15 mars 2001 :

Reprise du débat sur la motion de l'honorable sénateur Nolin, appuyée par l'honorable sénateur Molgat,

Qu'un comité spécial du Sénat soit formé afin de faire rapport sur :

- l'approche du Canada concernant le chanvre indien (cannabis), ses préparations et dérivés et les préparations synthétiques semblables, en contexte;

- l'efficacité de cette approche, les moyens de sa mise en oeuvre ainsi que le contrôle de son application;

- les politiques officielles pertinentes adoptées par d'autres pays;

- le rôle et les obligations internationales qui incombent au Canada en vertu des conventions des Nations Unies sur les stupéfiants relativement au cannabis, de la Déclaration universelle des droits de l'homme et d'autres traités connexes;

- les effets sociaux et sanitaires du cannabis et les effets possibles de politiques différentes;

Que le comité spécial soit composé de cinq sénateurs dont trois constituent le quorum;

Que les honorables sénateurs Banks, Kenny, Nolin et Rossiter (le cinquième membre sera nommé par le whip en chef du gouvernement) soient nommés au comité;

Que le comité ait le pouvoir de faire comparaître des personnes et produire des documents, d'entendre des témoins, de faire rapport au besoin et de faire imprimer au jour le jour documents, mémoires et témoignages selon les instructions du comité;

Que les mémoires reçus et les témoignages entendus lors de l'examen du projet de loi C-8, *Loi portant sur la réglementation de certaines drogues et de leurs précurseurs ainsi que d'autres substances, modifiant certaines lois et abrogeant la Loi sur les stupéfiants en conséquence* par le Comité sénatorial permanent des affaires juridiques et constitutionnelles durant la deuxième session de la trente-cinquième législature, soient envoyés au comité;

Que les documents et les témoignages recueillis sur le sujet par le Comité spécial sur les drogues illicites du Sénat durant la deuxième session de la trente-sixième législature soient envoyés au comité;

Que le comité soit habilité à autoriser, s'il le juge opportun, la radiodiffusion, la télédiffusion et la diffusion par les médias électroniques de la totalité ou d'une partie de ses délibérations et des informations qu'il détient;

Que le comité présente son rapport final au plus tard le 31 août 2002 et qu'il conserve les pouvoirs nécessaires à la diffusion de ses constatations pendant trente jours après le dépôt de son rapport;

Que le comité soit autorisé, indépendamment de l'usage habituel, à déposer son rapport auprès du greffier du Sénat si le Sénat ne siège pas, et que le rapport soit réputé avoir été déposé au Sénat.

Après débat,

La motion principale, telle que modifiée, mise aux voix, est adoptée.

Extrait des Journaux du Sénat du 9 mai 2002 :

L'honorable sénateur Nolin propose, appuyé par l'honorable sénateur Stratton,

Que la date de présentation du rapport final du Comité spécial du Sénat sur les drogues illicites au sujet de son étude de réexaminer des lois et des politiques antidrogue canadiennes, autorisée par le Sénat le 15 mars 2001, soit reportée du 31 août 2002 au 13 septembre 2002.

La motion, mise aux voix, est adoptée.

ATTESTÉ :

Le greffier du Sénat,

Paul C. Bélisle

REMERCIEMENTS

Je suis très fier du rapport sur le cannabis que le Comité spécial du Sénat sur les drogues illicites rend aujourd'hui public. Ce rapport marque une étape dans la politique publique canadienne sur les drogues et je ne doute pas que, malgré son volume imposant, il trouvera plus d'un lecteur attentif.

Ce rapport est le fruit de deux années d'un travail collectif. Au risque d'oublier certaines personnes qui me pardonneront, je veux exprimer ici ma reconnaissance pour les contributions de ceux et celles qui ont été associés le plus près à nos travaux.

Je tiens d'abord à remercier l'ensemble des Canadiens et Canadiennes qui, de près ou de loin, ont participé à nos travaux, en nous écrivant, en assistant à nos audiences et à nos débats publics dans les régions, en nous regardant à la télévision, et tout simplement en s'informant sur cette question importante de politique sociale. Leur apport, leurs questions, leurs commentaires, nous ont été source d'inspiration. Nous n'oublierons pas non plus l'accueil que nous ont fait les Chefs de la tribu des Piapot en Saskatchewan ; la cérémonie qu'ils nous ont offerte a été un véritable ressourcement.

Le travail du Comité n'aurait pas été possible sans l'immense contribution de son équipe de recherche. Cette petite équipe a été habilement dirigée par le Dr Daniel Sansfaçon, sociologue, dont la rigueur et le dévouement ont permis au Comité d'atteindre les plus hautes exigences de qualité pour l'ensemble de ses travaux et la rédaction de son rapport. À ses côtés, Monsieur Gérald Lafrenière et Madame Chantal Collin, analystes à la Direction de la recherche parlementaire de la Bibliothèque du Parlement, ont été des collègues inestimables. Qu'il me soit d'ailleurs permis de remercier explicitement la Direction de la recherche parlementaire et son directeur général qui ont répondu avec diligence et professionnalisme à notre imposant programme de recherche. Enfin, je veux souligner les contributions de Madame Barbara Buston Wheelock, assistante auprès de la Sénatrice Rossiter, de Monsieur François Dubois, mon assistant de recherche, ainsi que de Messieurs Jean-Guy Desgagné et David Newman aux communications.

Les travaux du Comité ont bénéficié de l'expertise et de la générosité des nombreux experts qui sont venus témoigner ou que nous avons rencontrés à titre privé et dont on trouvera la liste en annexe. Je voudrais les remercier tous et chacun.

Nous avons aussi pu compter sur la compétence des greffiers de comités et l'efficacité de leur personnel administratif pour l'organisation de nos multiples réunions de travail et réunions publiques. Je voudrais remercier messieurs Blair Armitage, Daniel Charbonneau et Adam Thompson.

Notre rapport, marqué par un grand souci de transparence et de rigueur, témoigne des plus hauts standards que le Sénat du Canada sait maintenir. Je voudrais d'ailleurs remercier mes collègues du Sénat qui nous ont accordé leur confiance en nous confiant ce mandat. En terminant je voudrais témoigner ma reconnaissance à mes collègues qui ont participé à nos travaux et tout spécialement à chacun des membres du Comité spécial du Sénat sur les drogues illicites, son vice-président, le sénateur Colin KENNY, et les sénateurs Tommy BANKS, Shirley MAHEU et Eileen ROSSITER. Ils ont fait un travail remarquable.

Collègues, je crois que les Canadiens ont raison d'être fiers de notre institution parlementaire.

Pierre Claude NOLIN
Sénateur
Président du Comité spécial du Sénat sur les drogues illicites

MEMBRES DU COMITÉ SPÉCIAL DU SÉNAT SUR LES DROGUES ILLICITES

1. MEMBRES DU COMITÉ SPÉCIAL DU SÉNAT SUR LES DROGUES ILLICITES

L'honorable Pierre Claude Nolin
(Président)

L'honorable Colin Kenny
(Vice-président)

L'honorable Tommy Banks

L'honorable Eileen Rossiter

L'honorable Shirley Maheu

L'honorable John Lynch-Staunton *

L'honorable Sharon Carstairs, c.p. * **

L'honorable Noël A. Kinsella *

L'honorable Fernand Robichaud, c.p.*

2. AUTRES SÉNATEURS AYANT PARTICIPÉ AUX TRAVAUX DU COMITÉ

L'honorable Michel Biron

L'honorable Laurier LaPierre

L'honorable Pat Carney, c.p.

L'honorable Jean Lapointe

L'honorable Thelma Chalifoux

L'honorable Edward M. Lawson

L'honorable Ione Christensen

L'honorable Lorna Milne

L'honorable Ethel M. Cochrane

L'honorable Yves Morin

L'honorable Pierre De Bané, c.p., c.r.

L'honorable Lucie Pépin ***

L'honorable Consiglio Di Nino

L'honorable Marie-P. Poulin

L'honorable Joyce Fairbairn, c.p.

L'honorable Marcel Prud'homme,c.p

L'honorable Sheila Finestone, c.p.

L'honorable Gerry St. Germain, c.p.

L'honorable J. Michael Forrestall

L'honorable Peter A. Stollery

L'honorable Jerahmiel S. Grafstein, c.r.

L'honorable Terry Stratton

L'honorable Mobina S.B. Jaffer

L'honorable John Wiebe

L'honorable Lois M. Wilson

* Membres d'office
** L'honorable Sharon Carstairs a été membre du Comité d'avril 2000 à octobre 2000
*** L'honorable Lucie Pépin a été membre du Comité d'avril 2000 à octobre 2000.

TABLE DES MATIÈRES

GLOSSAIRE DES PRINCIPAUX TERMES

INTRODUCTION 1

PREMIÈRE PARTIE – ORIENTATIONS GÉNÉRALES 5

CHAPITRE 1 – NOTRE MANDAT 7
LIBELLÉ 7
ORIGINES 9
NOTRE COMPRÉHENSION 11

CHAPITRE 2 – NOS TRAVAUX 13
DEUX PRINCIPES DE TRAVAIL 14
L'ÉTAT DES CONNAISSANCES 15
Le programme de recherche 19
Audiences de témoins experts 20
Le défi de la synthèse 22
TENIR COMPTE DES OPINIONS 23
INTERPRÉTER À LA LUMIÈRE DE PRINCIPES 24

CHAPITRE 3 – NOS PRINCIPES DIRECTEURS 25
L'ÉTHIQUE, OU LE PRINCIPE DE L'AUTONOMIE RÉCIPROQUE 28
LA GOUVERNANCE : MAXIMISER L'ACTION DES INDIVIDUS 32
La gouvernance de la collectivité 34
La gouvernance de soi 36
Le rôle de la gouvernance 37
LE DROIT PÉNAL OU LES LIMITES DE L'INTERDICTION 38
Nécessité de la distinction 39
Critères de distinction 41
Application aux drogues illicites 45
LA SCIENCE OU LA CONNAISSANCE APPROCHÉE 46
CONCLUSIONS 51

CHAPITRE 4 – UN CONTEXTE EN MOUVANCE **53**
MUTATIONS DU CONTEXTE INTERNATIONAL 53
Globalisation et intégration 53
Errances d'un discours sécuritaire 57
Des politiques antidrogues aux politiques sur les drogues 59
MUTATIONS AU CANADA 61
L'activisme judiciaire 61
Une stratégie nationale de prévention du crime 62
La lutte au crime organisé 62
UN DÉBAT DE SOCIÉTÉ 63

PARTIE II – LE CANNABIS : EFFETS, USAGES, ATTITUDES **65**

CHAPITRE 5 – LE CANNABIS : DE LA PLANTE AU JOINT **67**
UNE PLANTE, DIVERSES DROGUES 68
ROUTES DU CANNABIS 72
PROPRIÉTÉS DU CANNABIS 79
Concentration en Δ^9THC 80
PHARMACOCINÉTIQUE 86
CONCLUSIONS 90

CHAPITRE 6 – USAGERS ET USAGES : FORMES, PRATIQUES, CONTEXTES **93**
TENDANCES D'USAGE 94
Consommation en population générale 95
Consommation chez les jeunes 99
Tendances d'usage dans d'autres pays 105
Éléments de synthèse 114
FORMES ET MODES D'USAGE 116
Le cannabis dans l'histoire 117
Trajectoires d'usages 119
Facteurs reliés à l'usage 125
Éléments de synthèse 131
UNE ESCALADE VERS D'AUTRES DROGUES ? 132
CANNABIS, VIOLENCE ET CRIMINALITÉ 134
CONCLUSIONS 136

CHAPITRE 7 – LE CANNABIS : EFFETS ET CONSEQUENCES **139**
EFFETS ET CONSÉQUENCES DU CANNABIS : CE QU'ON NOUS A DIT 142
EFFETS AIGUS DU CANNABIS 148
CONSÉQUENCES DE LA CONSOMMATION CHRONIQUE 152
Conséquences physiologiques de l'usage chronique 153
Conséquences cognitives et psychologiques 158
Conséquences comportementales et sociales 162
TOLÉRANCE ET DÉPENDANCE 163
Dépendance au cannabis 164
Sévérité de la dépendance 171
La tolérance 174
ÉLÉMENTS DE SYNTHÈSE 175
CONCLUSIONS 176

CHAPITRE 8 – CONDUITE SOUS L'EFFET DU CANNABIS **179**
MODES DE DÉPISTAGE 182
DONNÉES ÉPIDÉMIOLOGIQUES 187
Études hors contexte accidentel 188
Études en contexte accidentel 189
Enquêtes épidémiologiques auprès des jeunes 192
Évaluation du risque 192
ÉTUDES EXPÉRIMENTALES 195
Activités hors conduite 195
En activité de conduite 197
CONCLUSIONS 201

CHAPITRE 9 – APPLICATIONS THÉRAPEUTIQUES DU CANNABIS **203**
ASPECTS HISTORIQUES 208
CONNAISSANCES CONTEMPORAINES 210
Utilisations thérapeutiques 210
Le cannabis comme médicament ? 213
PRATIQUES THÉRAPEUTIQUES ACTUELLES 216
CONCLUSIONS 219

CHAPITRE 10 – OPINIONS ET ATTITUDES DES CANADIENS **221**
LES MÉDIAS 222
ENQUÊTES ET SONDAGES 227
ATTITUDES ET OPINIONS EXPRIMÉES AU COMITÉ 234
CONCLUSIONS 237

PARTIE III – POLITIQUES ET PRATIQUES AU CANADA **239**

CHAPITRE 11 – UNE STRATÉGIE CANADIENNE ANTIDROGUE ? **241**
PHASE I – ÉLABORATION ET MISE EN PLACE 242
Création du Centre canadien de lutte contre l'alcoolisme et les toxicomanies 248
Création du Secrétariat de la Stratégie canadienne antidrogue 250
PHASE II – RENOUVELLEMENT 252
PHASE III – LE RENOUVELLEMENT SANS FINANCEMENT PRÉCIS 255
LA STRATÉGIE CANADIENNE ANTIDROGUE – UNE RÉUSSITE ? 257
CONCLUSIONS 259

CHAPITRE 12 – LE CONTEXTE LÉGISLATIF NATIONAL **261**
1908-1960 : L'HYSTÉRIE 264
La Loi sur l'opium de 1908 269
Loi sur l'opium et les narcotiques de 1911 269
Les amendements à la Loi sur l'opium et les narcotiques (1920-1938) 272
Les modifications à la Loi sur l'opium et les narcotiques en 1954 281
Le rapport du Sénat de 1955 282
DE 1960 À LA COMMISSION LE DAIN : À LA RECHERCHE DES RAISONS PERDUES 286
La Loi sur les stupéfiants (1961) 286
La Loi sur les aliments et drogues et les barbituriques (1961) 288
La Commission Le Dain (1969-1973) 291
Le projet de loi S-19 et le cannabis 302

APRÈS LE DAIN : LA FUITE EN AVANT 303
La Loi réglementant certaines drogues et autres substances 305
CONCLUSIONS 315

CHAPITRE 13 – RÉGLEMENTER L'UTILISATION DU CANNBIS À DES FINS THÉRAPEUTIQUES **317**
CADRE ENTOURANT LA RÉCENTE RÉGLEMENTATION 318
Article 56 – Loi réglementant certaines drogues et autres substances 318
Contestations fondées sur la Charte – utilisation de la marijuana à des fins thérapeutiques 320
Réaction du gouvernement 322
RÉGLEMENTATION SUR L'ACCÈS À LA MARIJUANA À DES FINS MÉDICALES 323
Autoristion de posséder 324
Licences de production 328
Autres dispositions 329
ACCÈS HUMANITAIRE ? 329
Admissibilité 330
Accès au cannabis 335
Produits 338
Coûts 338
POURSUIVRE LA RECHERCHE 340
Recherche scientifique 340
Marijuana propre à la recherche 343
CONCLUSIONS 344

CHAPITRE 14 – PRATIQUES POLICIÈRES **347**
ORGANISMES D'EXÉCUTION DE LA LOI 347
GRC 347
L'Agence des douanes et du revenu du Canada 350
Polices municipales et provinciales 352
COÛTS 353
POUVOIRS POLICIERS 358
Fouilles perquisitions et saisies 360
La provocation policière et les activités illégales 374
Conclusion 379
STATISTIQUES 380
Incidents relatés 380
Accusations 383
Inquiétudes 386
La Loi sur les douanes – amendes 389
SAISIES 390
CONCLUSIONS 392

CHAPITRE 15 – LE SYSTÈME DE JUSTICE PÉNALE **393**
POURSUITES 393
TRIBUNAUX 394
Les tribunaux de traitement de la toxicomanie 395
DÉCISION ET DÉTERMINATION DE LA SANCTION 399
SERVICE CORRECTIONNEL 402
CASIER JUDICIAIRE 406
CONTESTATIONS JUDICIAIRES 409
CONCLUSIONS 415

CHAPITRE 16 – PRATIQUES PRÉVENTIVES **417**
DES ACTIONS QUI NE SONT PAS À LA HAUTEUR DES DISCOURS 421
On ne fait pas suffisamment de prévention 422
La prévention est insuffisamment ciblée 424
On ne fait pas suffisamment l'évaluation des mesures de prévention 426
Les messages sociaux contredisent les messages de prévention 427
Il existe une connaissance dont il faut s'inspirer 428
PRÉVENIR : QUOI ? COMMENT ? 429
RÉDUCTION DES RISQUES, RÉDUCTION DES MÉFAITS 441
CONCLUSIONS 443

CHAPITRE 17 – PRATIQUES DE SOINS **445**
DÉPENDANCES AU CANNABIS 445
FORMES DE TRAITEMENT 451
L'EFFICACITÉ DES TRAITEMENTS 453
CONCLUSIONS 456

CHAPITRE 18 – OBSERVATIONS SUR LES PRATIQUES **457**
DES DIFFICULTÉS D'ARTICULATION ENTRE LES ACTEURS 457
UN ARRIMAGE DIFFICILE ENTRE LES APPROCHES 459
DES COÛTS ÉCONOMIQUES ET SOCIAUX IMPORTANTS 462
CONCLUSIONS 467

PARTIE IV – OPTIONS DE POLITIQUE PUBLIQUE **469**

CHAPITRE 19 – LE CONTEXTE JURIDIQUE INTERNATIONAL **471**
ÉLÉMENTS DE GÉNÉALOGIE 472
La Conférence de Shanghai (1909) 475
La Convention internationale de l'opium de 1912 (La Haye) 477
Les Conventions de l'opium de Genève (1925) 479
La Convention de Genève pour limiter la fabrication et réglementer la distribution des stupéfiants (1931) / Accord de Bangkok sur la consommation d'opium (1931) 480
La Convention pour la répression du trafic illicite des drogues nuisibles (Genève, 1936) 482
La Deuxième Guerre mondiale 482
Le Protocole de LakeSuccess (1946) 483
Le Protocole de Paris (1948) 483
Le Protocole de l'opium de New York (1953) 484
LES TROIS CONVENTIONS ACTUELLES 485
La Convention unique sur les stupéfiants de 1961 485
Convention sur les substances psychotropes 490
Protocole portant amendement à la Convention unique sur les stupéfiants de 1961 496
Convention contre le trafic illicite de stupéfiants et de substances psychotropes 498
UNE MARGE DE MANŒUVRE ? 501
CONCLUSIONS 504

CHAPITRE 20 – POLITIQUES PUBLIQUES DANS D'AUTRES PAYS 507
FRANCE 508
Des logiques distinctives 508
Une politique publique intégrée 510
Cadre législatif 513
Quelques rapports clés 516
Statistiques sur l'usage et la répression 520
Coûts 523
PAYS-BAS 524
Le pragmatisme néerlandais ? 525
Des rapports d'experts fondateurs 527
La législation 533
Le régime des coffee shops 536
Données sur l'usage 538
ROYAUME-UNI 542
Stratégie décennale de lutte contre la toxicomanie 542
Cadre législatif 543
Autres lois pertinentes au domaine de la toxicomanie 546
Débats au RU 547
Études et rapports récents 548
Administration 556
Coûts 556
Statistiques 558
LA SUÈDE 560
Stratégie nationale 562
Cadre législatif 566
Le débat en Suède 568
Rapports récents 569
Coûts 571
Administration 572
Statistiques 572
LA SUISSE 575
Une politique de réduction des risques 575
Évolution du régime juridique 583
Un projet de dépénalisation du cannabis 585
Administration de la politique suisse en matière de drogue 587
Statistiques sur l'usage de stupéfiants et les infractions à la LStup 589
L'AUSTRALIE 592
Stratégie nationale sur les drogues 592
Le cadre législatif 597
Décriminalisation du cannabis 601
Administration 603
Statistiques 605
LES ÉTATS-UNIS 607
Le cadre législatif de l'administration fédérale et des États 607
La législation actuelle et son application 610
Buts et objectifs de la politique fédérale de lutte contre les stupéfiants 619
Administration de la politique 622
Sujets d'actualité et débats 624
Statistiques 626

CHAPITRE 21 – OPTIONS DE POLITIQUE PUBLIQUE 631
L'INEFFICACITÉ DES POLITIQUES PÉNALES 633

Des impacts sur la consommation ? 634
Des impacts sur l'offre ? 640
Conclusion 640
ÉCONOMIE GÉNÉRALE D'UNE POLITIQUE PUBLIQUE SUR LE CANNABIS 641
COMPOSANTES D'UNE POLITIQUE PUBLIQUE 644
Un centre de responsabilité fort 644
Interconnexion 645
Élaboration en commun d'objectifs partagés 645
Des outils de connaissance 645
OPTIONS LÉGISLATIVES 646
Clarifications terminologiques 646
Critères pour une politique juridique sur le cannabis 654

CONCLUSIONS ET RECOMMANDATIONS 659

IL Y A TRENTE ANS, LE DAIN 659
L'INEFFICACITÉ DES PRATIQUES ACTUELLES 661
UNE POLITIQUE PUBLIQUE BASÉE SUR DES PRINCIPES DIRECTEURS 663
UNE STRATÉGIE FÉDÉRALE CLAIRE ET COHÉRENTE 664
UNE STRATÉGIE NATIONALE SOUTENUE PAR DES MOYENS ET DES OUTILS 665
UNE POLITIQUE DE SANTÉ PUBLIQUE 667
UNE APPROCHE RÉGLEMENTAIRE SUR LE CANNABIS 670
UNE APPROCHE DE COMPASSION POUR LES USAGES THÉRAPEUTIQUES 671
DISPOSITIONS SUR LA CONDUITE SOUS L'INFLUENCE DU CANNABIS 672
POURSUIVRE LA RECHERCHE 673
POSITIONNEMENT INTERNATIONAL DU CANADA 674

PROPOSITIONS DE MISE EN ŒUVRE DE LA RÉGLEMENTATION DU CANNABIS AUX FINS THÉRAPEUTIQUES ET RÉCRÉATIONNELLES 676

BIBLIOGRAPHIE 681

GLOSSAIRE DES PRINCIPAUX TERMES

Abus
Terme vague qui reçoit une grande variété de significations, selon les contextes sociaux, médicaux, et juridiques. Selon certains, tout usage de drogues illicites est un abus : ainsi, les conventions internationales considèrent l'usage de toute substance prohibée pour des fins autres que médicales ou scientifiques comme un abus. Le Manuel diagnostic de l'Association américaine de psychiatrie définit l'abus comme un mode d'utilisation inadéquat d'une substance conduisant à une altération du fonctionnement ou à une souffrance cliniquement significative, et suggère 4 critères (voir le chapitre 7 du rapport). Nous lui préférons le concept d'usage excessif (ou usage nocif).

Accoutumance *(de l'anglais addiction)*
Terme général renvoyant aux phénomènes de tolérance et de pharmacodépendance. Le terme accoutumance est rarement utilisé en français qui utilise plutôt le terme toxicomanie.

Addiction
Certains auteurs utilisent ce terme issu de l'anglais pour désigner le processus par lequel un comportement, pouvant permettre une production de plaisir et d'écarter une sensation de malaise interne, est employé de façon caractérisée par l'impossibilité répétée de contrôler ce comportement et sa poursuite en dépit de la connaissance de ses conséquences négatives. Ces auteurs le préfèrent au concept de dépendance, celui-ci ne permettant pas de travailler sur la période qui précède la dépendance. Nous lui préférons le terme dépendance.

Agoniste
Se dit entre autres d'une substance qui agit sur un récepteur pour produire certaines réponses.

Anandamide
Neurotransmetteur agoniste du système cannabinoïde endogène. Bien que les rôles spécifiques de ces neurotransmetteurs ne soient pas encore définis, ils semblent agir comme des neuromodulateurs ; en effet, le THC augmente la libération de dopamine du noyau accumbens et du cortex préfrontal.

Cannabinoïdes
Récepteurs endogènes des molécules actives du cannabis, notamment le THC. Deux récepteurs endogènes ont été identifiés : CB_1 existent en grande densité dans l'hippocampe, le ganglion basal, les corps cérébelleux, et le cortex cérébral et CB_2, ils sont particulièrement abondants dans le système immunitaire Les effets centraux du cannabis semblent être exclusivement reliés aux récepteurs CB_1.

Cannabis
Il existe trois variétés de plantes de cannabis, le *cannabis sativa*, le *cannabis indica*, et le *cannabis ruredalis*. La plante de la variété *cannabis sativa* est la plus répandue poussant dans presque tous les sols. La plante de cannabis est connue en Chine depuis environ 6000 ans. À partir des sommités florifères de la plante de cannabis, mais aussi parfois des feuilles, on obtient le tabac à fumer. Sous cette forme, l'appellation la plus courante est le pot, mais on le désigne aussi sous le nom de mari, herbe, dope, ganja. La résine extraite de la plante sert à fabriquer le haschich.

Généralement classifié sous les psychotropes, le cannabis est un perturbateur du système nerveux central. Le cannabis contient plus de 460 produits chimiques connus, dont plus de 60 sont désignés sous le nom de cannabinoïdes. Le principal ingrédient actif du cannabis est le delta-9-tétrahydrocannabinol, communément appelé THC. D'autres cannabinoïdes présents incluent le delta-8-tétrahydrocannabinol, le cannabinol et le cannabidiol mais ils sont présents en faibles quantités et n'exercent pas d'effets significatifs sur le comportement des individus, comparativement au THC. Ils peuvent cependant contribuer à moduler l'effet global du produit. Dans le rapport, nous utilisons le terme cannabis pour désigner l'ensemble des produits, et n'utilisons marijuana ou haschich que lorsque nous désignons ces dérivés spécifiquement.

Commission sur les drogues (CND)
La Commission sur les narcotiques a été créé en 1946 par le Conseil économique et social des Nations Unies. La Commission est le principal organisme d'élaboration de politiques sur les drogues au sein du système onusien. Elle examine la situation mondiale relativement à l'abus de drogues et fait des propositions pour renforcer le contrôle international des drogues.

Conduite (ou usage) à risque
Comportement d'usage qui met la personne à risque de développer des problèmes de dépendance à la substance. La conduite à risque se compose de l'interaction complexe entre au moins quatre facteurs : le contexte d'usage, la quantité consommée, la fréquence de la consommation et la durée et l'intensité de la consommation. (Nous proposons des critères à la conclusion du rapport).

Conventions internationales
Sous l'égide de la Société des Nations en 1908 puis des Nations Unies, diverses conventions internationales réglementent la possession, l'usage, la fabrication, la distribution, le commerce, etc., des substances psychotropes. Les trois principales conventions sont celles de 1961, 1971 et 1988. Le Canada a ratifié ces trois conventions. Ces conventions, dont l'application est assujettie aux lois constitutionnelles des signataires, établissent un système de réglementation où seuls les usages aux fins médicales et scientifiques sont permis. Ce système est axé sur la prohibition des plantes source (coca, opium et cannabis) et sur le contrôle des dérivés synthétiques fabriqués par les compagnies pharmaceutiques.

Décriminalisation
Opération consistant à retirer un comportement de la «compétence » du système de justice criminelle. On distingue habituellement entre *décriminalisation de droit (ou de jure)* impliquant une modification *législative* du Code criminel (ou de toute loi de nature criminelle)et *décriminalisation de fait (ou de facto)* où il s'agit d'une décision administrative de ne pas poursuivre le comportement qui demeure cependant illégal. La décriminalisation ne concerne que le Code criminel (ou toute loi de nature criminelle), et ne signifie pas que l'on retire la compétence du système juridique dans son ensemble. D'autres lois non criminelles peuvent réguler et contrôler le comportement qui a été décriminalisé (infractions civiles, réglementaires, etc.).

Déjudiciarisation
Réfère aux mesures alternatives à la poursuite ou à la condamnation pénale d'un acte qui demeure par ailleurs prohibé. La déjudiciarisation peut se faire avant la mise en accusation, par exemple si la personne inculpée consent à suivre un traitement. Elle peut aussi se faire au moment de la sanction, et prend alors la forme de sanctions de travail communautaire ou de traitement.

Demi-vie
Temps requis pour la diminution de moitié de la concentration d'une drogue dans le sang. La demi-vie d'élimination du THC est en moyenne de 4,3 jours. Suite au phénomène de tolérance métabolique, les consommateurs réguliers métabolisent et excrètent le produit plus rapidement que les usagers occasionnels. D'autre part, à cause de sa très grande liposolubilité, l'administration répétée du THC provoque son accumulation dans les graisses. Du fait de ce stockage graisseux, la demi-vie d'élimination tissulaire du THC peut atteindre 7 à 12 jours chez les consommateurs réguliers. La consommation prolongée du cannabis se traduit donc par une période d'élimination plus longue du THC. Ainsi, même après une semaine, 20 à 30 % du THC administré et ses métabolites demeurent dans l'organisme. Le THC et ses métabolites sont graduellement excrétés dans l'urine (environ un tiers) et dans les matières fécales (environ deux tiers). Des traces de THC ou de ses métabolites peuvent être détectées dans l'urine jusqu'à 30 jours après sa consommation

Dépénalisation
Opération consistant à modifier les peines (sanctions) associées à un acte dans le Code criminel. La dépénalisation signifie la plupart du temps le fait d'abroger les dispositions permettant une sanction d'incarcération.

Dépendance
État où l'usager de drogue continue de consommer même si l'usage entraîne des problèmes qui peuvent être d'ordre physique, psychologique, relationnel, familial, ou social. La dépendance est un phénomène complexe qui peut avoir des composantes génétiques. La dépendance psychologique renvoie aux effets psychiques caractérisés par le désir insistant et persistant de consommer la drogue. La dépendance physique renvoie aux mécanismes d'adaptation de l'organisme à la consommation prolongée et peut s'accompagner d'une tolérance acquise. L'Association psychiatrique américaine propose 7 critères (voir chapitre 7).

Dopamine
Neuromédiateur impliqué notamment dans les mécanismes de perception du plaisir.

Drogue
Terme qui renvoie généralement aux substances illicites par opposition à d'autres substances telles l'alcool, la nicotine ou des médicaments psychotropes. En pharmacologie, le terme réfère à tout agent chimique qui modifie les processus biochimiques ou physiologiques des tissus ou de l'organisme. En ce sens, le terme drogue s'applique à toute substance qui est consommée principalement pour ses effets psychoactifs.

Effets aigus
Se dit des effets résultant de l'action ponctuelle d'un médicament et généralement des effets à court terme. Ces effets peuvent être centraux (sur les fonctions cérébrales) ou périphériques (sur le système nerveux).

Effets chroniques
Se dit des effets qui se développent avec le temps, à la suite de la prise ou de l'administration régulière d'une substance. Dans le rapport, nous avons préféré parler des conséquences de l'usage prolongé plutôt que d'effets chroniques.

Escalade (théorie de)
Théorie qui suggère une séquence progressive dans l'utilisation des drogues, nicotine, alcool, cannabis, puis les drogues « dures ». Elle repose sur une association statistique entre l'usage de drogues dures et le fait que ces personnes aient d'abord consommé du cannabis. Cette théorie n'a reçu aucune validation empirique et est tombée en désuétude.

Haschich
Résine issue de la plante de cannabis et transformée en pâte.

Intoxication
Perturbations qu'exerce une substance sur l'organisme. On distingue généralement quatre niveaux d'intoxication : légère, modérée, grave et mortelle.

Joint
Cigarette de marijuana, avec ou sans tabac. Le fait que deux cigarettes ne soient jamais identiques rend difficile l'analyse scientifique des effets du principe actif, notamment pour les études sur le cannabis thérapeutique.

Légalisation
Système de réglementation permettant la culture, production, fabrication, commercialisation, vente et usage de substances. Un système de légalisation peut être avec (réglementation) ou sans (libre marché) contrôles de l'État.

Liposolubilité
Propriété biophysique d'une substance de se répandre et se dissoudre plus ou moins facilement dans les graisses de l'organisme. Le THC est très liposoluble.

Marijuana
Nom mexicain qui désigne initialement une cigarette de mauvaise qualité. Par extension est devenu un équivalent pour désigner le cannabis.

Narcotique
Substance provoquant un état de torpeur ou un sommeil artificiel.

Observatoire européen des drogues et des toxicomanies (OEDT)
L'OEDT a été créé en 1993 pour apporter à la Communauté européenne et à ses États membres "des informations objectives, fiables et comparables au niveau européen sur le phénomène des drogues et des toxicomanies et leurs conséquences". Les informations statistiques, documentaires et techniques traitées ou produites par l'Observatoire fournissent à son audience une image d'ensemble sur le phénomène des drogues en Europe. L'Observatoire travaille uniquement dans le domaine de l'information. Il est composé d'un réseau de correspondants nationaux dans chacun des pays de l'Union.

Organe international de contrôle des stupéfiants (OICS)
L'Organe international de contrôle des stupéfiants (OICS ou Organe) est un organisme de contrôle indépendant et quasi-judiciaire chargé de l'application des conventions des Nations Unies sur les drogues; il a été créé en 1968 par la Convention unique sur les stupéfiants de 1961. Il a eu des prédécesseurs créés par les précédentes conventions sur les drogues, dès l'époque de la Société des Nations. L'organe est maintenant chargé de faire des recommandation à la

Commission sur les narcotiques relativement aux substances à placer dans les annexes des conventions.

Organisation mondiale de la santé (OMS)
Créée en 1948, l'OMS est l'agence des Nations Unis spécialisée dans les questions de santé. Son mandat est de favoriser le plus haut degré de santé possible. La santé est définie comme un état global de bien-être physique, psychologique et social et non seulement comme l'absence de maladie ou d'infirmité.

Office of national drug control policy (ONDCP) USA
Office national sur la politique de contrôle des drogues. Créé en 1984 sous la présidence Reagan, l'Office relève de la Maison Blanche. L'Office coordonne la politique américaine sur les drogues et gère un budget d'environ 18 milliards $ US par année.

Opiacé
Substance contenant de l'opium ou exerçant une action comparable à celle de l'opium.

Pharmacodépendance
Voir dépendance.

Porte d'entrée (théorie de la)
Aussi nommée théorie de l'introduction. Semblable à la théorie de l'escalade mais renvoie plus spécifiquement au fait que les personnes qui se procurent du cannabis viennent en contact avec des milieux potentiellement criminogènes du fait que le cannabis soit illégal.

Programme des Nations Unies pour le contrôle international des drogues (PNUCID)
Mieux connu sous l'acronyme anglais UNDCP. Fondé en 1991, le Programme a pour objectif d'informer le monde sur les dangers de l'abus de drogues. Le programme vise à renforcer l'action internationale contre la production, le trafic et la criminalité reliée aux drogues en proposant des programmes de développement alternatif, de monitoring des cultures et de lutte au blanchiment d'argent. Le programme d'évaluation globale veut aussi fournir des données fiables et le programme d'assistance juridique aide les pays à rédiger des lois adéquates ainsi qu'à former le personnel du système de justice. Le PNUCID relève du Bureau des Nations Unies pour le contrôle des drogues et la prévention du crime.

Prohibition
Terme issu historiquement de la prohibition de l'alcool aux États-Unis entre 1919 et 1933. Par extension, ce terme renvoie aux politiques poursuivies par les États et par les Nations Unies qui visent une société sans drogue. La prohibition est un système fondé sur l'interdiction de la fabrication et de l'usage de drogues à l'exception des usages scientifiques et médicaux.

Psychotrope
Substance qui agit sur le psychisme en modifiant le fonctionnement mental, entrainant des changements dans les perceptions, l'humeur, la conscience, le comportement et diverses fonctions psychologiques et organiques. De manière spécifique réfère aux médicaments utilisés dans le traitement de désordres mentaux, tels les neuroleptiques, les anxiolytiques, etc. Renvoie aux médicaments couverts par la Convention de 1971.

Réglementation
Système de contrôle qui précise les conditions sous lesquelles il est permis de fabriquer, produire, commercialiser, prescrire, vendre ou acheter une substance. La réglementation peut être axée sur la prohibition (comme c'est le cas actuellement pour les drogues illicites) ou sur l'accès contrôlé (comme pour les médicaments psychotropes et l'alcool). Notre proposition de régime d'exemption sous conditions repose sur une approche réglementaire.

Société des Nations (SDN)
Prédécesseur de l'ONU, la SDN était l'organisation internationale des états jusqu'en 1938.

Stupéfiant
Se dit souvent des substances dont les effets psychoactifs peuvent entrainer des effets de tolérance et de dépendance. Plus correctement, ce terme ne devrait s'utiliser que pour désigner les dépresseurs du système nerveux central tels les opiacés.

Substance psychoactive
Substance qui modifie les processus mentaux tels la pensée ou les émotions. Terme plus neutre que drogue, et qui ne distingue pas les substances selon leur statut juridique (licites, illicites) c'est celui que nous préférons utiliser dans le rapport.

Tétrahydrocannabinol (Δ9-THC)
Principal composant actif du cannabis, le Δ9-THC est très liposoluble, a une demi-vie d'élimination très longue, et ses effets psychoactifs sont modulés par les autres cannabinoïdes du cannabis. À l'état naturel, le cannabis contient entre 0,5 % et 5 % de concentration en THC. Les modes de culture sophistiqués, la sélection des plants, le choix entre des plants femelles, permettent d'atteindre des concentrations plus élevées, pouvant dans certains cas aller jusqu'à 30 %.

Tolérance
État induit par la consommation chronique d'une substance menant à une diminution de la réponse de l'organisme et une capacité plus grande de supporter ses effets.

Toxicité
Qualité spécifique à une substance d'entrainer l'intoxication. Le cannabis a une toxicité très faible et ne présente à peu près aucun risque de surdose.

Toxicomanie
Terme le plus fréquemment utilisé en langue française pour désigner les phénomènes que l'anglais désigne sous le terme *addiction*. Usage répété d'une ou plusieurs substances de telle sorte que l'usager (alors désigné sous le terme «toxicomane ») est en état régulier ou chronique d'intoxication, ressent le besoin de consommer, a de la difficulté à cesser la prise, et cherche à se procurer la substance. Cet état est généralement caractérisé par la tolérance et la dépendance à la substance ainsi que par un usage compulsif. Malgré son usage répandu, l'OMS a recommandé dès 1960 d'en abandonner l'usage pour cause d'imprécision, et de lui préférer le terme de dépendance.

INTRODUCTION

La question des drogues illicites fait partie de ces enjeux de société qui prennent aisément une tournure morale, sinon simplement émotive. Qui d'entre nous n'a pas ses opinions sur les drogues et les «drogués » ? Qui ne connaît pas, de loin ou de proche, un parent, une amie, un jeune cousin, un oncle, qui a connu des difficultés personnelles, à l'école, au travail, peut-être même des démêlés avec la police et la justice, en raison de sa consommation de drogues ? Qui n'a pas entendu parler de ces trafiquants de drogues, véritables antihéros qui à la fois nous révulsent et nous fascinent, et qu'au total on assimilera aisément à une racaille de la pire espèce qui s'enrichit en vendant des produits plus ou moins frelatés, plus ou moins dangereux, à *nos* enfants ? Chaque jour connaît sa ration d'articles de journaux et de reportages télévisés, sur les opérations antidrogues menées par les forces policières : arrestations parfois massives, presque toujours spectaculaires, saisies de quantités de kilos de drogues, d'argent, d'armes de toutes sortes. Chaque jour connaît aussi sa ration d'articles sur le blanchiment d'argent et la corruption que le marché illicite des drogues entraîne dans son sillage. Plus près de nous encore, les événements du 11 septembre ont ramené à l'avant-scène les relations ambiguës et présumées entre le trafic de drogues et le financement de réseaux de « terroristes », tout comme ils ont mené à un discours politique et juridique où la sécurité est le maître mot.

La question des drogues touche à des valeurs politiques du vivre en commun. Dans quel genre de société voulons-nous vivre ? Quelle est la place que doivent, que peuvent, y occuper les drogues ? Pour certains, les drogues sont des substances qui maintiennent les individus dans un état de dépendance. Leur utilisation affaiblit les capacités morales, quand elle ne traduit pas tout simplement la préexistence de faiblesses de caractère ; sinon source de déchéance, les drogues empêchent les usagers d'atteindre leur plein épanouissement et la pleine réalisation de leur potentiel et diminue en tout cas leur capacité d'être des individus productifs dans la société. Pour d'autres, les drogues sont au contraire des outils pour atteindre à une productivité plus grande, pour être plus compétitifs et partant mieux insérés dans un monde lui-même hyper-compétitif. L'exemple évident est celui des athlètes de haut niveau. Pour d'autres encore elles sont un moyen privilégié d'entrer en contact avec d'autres dimensions de leur être, dimensions spirituelles, artistiques, ou tout simplement de paix et de sérénité. L'histoire de l'art est pleine d'exemples. Entre ces conceptions presque diamétralement opposées, il y a souvent peu de place au dialogue et beaucoup de préjugés entre les uns et les autres.

Depuis une vingtaine d'années, nous avons adopté des programmes vigoureux de lutte antitabac. Et nous avons certainement enregistré un certain nombre de succès. Nous avons aussi adopté des mesures plus sévères pour réprimer la conduite avec facultés affaiblies. Ici aussi, nous pensons avoir enregistré des progrès significatifs. La lutte aux drogues devient une sorte de métaphore du type de politiques sociales que nous attendons des gouvernements : politiques axées sur le mieux-être des citoyens.

Évidemment, tout dépend de ce que chacun met dans le mot drogues. Lorsque nous pensons à « drogue », nous avons d'abord en tête les substances illicites : cocaïne et héroïne bien entendu, crack, ecstasy et amphétamines pour les plus « branchés », et bien sûr le cannabis et le haschich que nous avons tendance à identifier comme drogues « douces » Or, de plus en plus de travaux scientifiques et des politiques gouvernementales s'efforcent de réduire la distance entre les diverses drogues, montrant plutôt les liens qu'elles entretiennent, discutant des conduites à risque relatives à chaque produit. Pour certains, en France par exemple, le simple fait de considérer l'alcool comme une drogue signifie une véritable révolution culturelle. Et pour les fabricants de tabac, la nicotine n'est certainement pas à ranger dans la même classe que l'héroïne.

C'est comme tout un chacun que les membres du **Comité spécial du Sénat sur les drogues illicites** ont abordé la question des drogues. C'est-à-dire avec les mêmes préconceptions, avec les mêmes attitudes de base, les mêmes craintes, les mêmes angoisses. Certes, nous disposions de l'étude que plusieurs de nos collègues avaient faite en 1996 du projet de loi du gouvernement sur les drogues illicites qui leur avait permis d'entendre plusieurs témoins durant quelques mois. Et nous savions aussi, en commençant ce travail, que nous disposerions de l'expertise de chercheurs. Mais qu'on ne se fasse pas d'illusion : il demeure difficile de dépasser les attitudes et opinions longtemps tenues pour acquises. Qu'on soit tenant d'un contrôle pénal renforcé ou tout au contraire d'une libéralisation plus grande, les opinions ont tendance à résister aux faits. D'autant plus que, dans un domaine comme celui-ci, la production des faits, même par la recherche scientifique, n'est pas nécessairement neutre. Il s'ensuit donc que **nous aussi, comme vous,** nous avons nos préjugés et nos préconceptions. Et que nous devons, ensemble, faire l'effort de les dépasser. C'est l'un des objectifs que poursuit ce rapport.

Notre rapport se divise en quatre parties. La première fait état de nos orientations générales et comprend quatre chapitres. Le premier rappelle l'origine du Comité et son mandat. Le second chapitre décrit les travaux que nous avons entrepris, explicitant certains choix que nous avons faits. Le troisième, central à toute l'architecture du rapport, en fournit en quelque sorte une grille de lecture. Ce chapitre propose en effet ce que nous avons appelé des **principes directeurs** pour une politique publique sur les drogues illicites. Enfin, le quatrième chapitre offre un large panorama de la situation contemporaine relative aux drogues illicites, situant nos travaux dans un contexte de changements et de mutations qui se produisent dans divers pays et plus généralement sur la scène internationale.

La seconde partie est au cœur même de notre rapport. Elle présente en effet l'ensemble des résultats issus de la recherche scientifique ainsi que des opinions des experts que nous avons entendus. Le chapitre 5 décrit la plante d'où sont issus le cannabis et le haschich que l'on fume, présente quelques données sur les sources de production du cannabis et ses principales voies de circulation, et examine les propriétés pharmacologiques des cannabinoïdes qui sont leur ingrédient actif. Le chapitre 6 présente les données relatives aux usages et aux usagers : qui consomme du cannabis, dans quelles circonstances, que connaît-on de leurs trajectoires de consommateurs, notamment la question hautement controversée de savoir si la consommation de cannabis mène à l'usage d'autres drogues. Le chapitre 7 décrit les effets et conséquences du cannabis aux plans physique et psychologique, s'arrêtant notamment aux questions importantes de la dépendance et de la tolérance au cannabis. En raison de son importance dans les débats de société sur les substances psychoactives capables d'avoir un effet sur les facultés cognitives et psychomotrices, le chapitre 8 porte spécifiquement sur la conduite de véhicules automobiles sous l'influence du cannabis. Par ailleurs, tenant compte de la place particulière qu'occupe présentement la question des usages thérapeutiques du cannabis, le chapitre 9 y est consacré. Finalement, le dernier chapitre de cette section discute de la connaissance de l'opinion publique. Nous y décrirons les sondages et enquêtes en population générale, mais nous y rapporterons aussi les propos qui nous ont été tenus lors des consultations que nous avons menées dans les régions suite à la publication en mai 2002 de notre document de discussion.

La troisième partie s'arrête aux politiques et pratiques au Canada. Quand on pense aux drogues, on pense immédiatement à la législation qui les régit. On oublie ainsi qu'une politique publique est faite de bien autre chose que de la loi, que celle-ci n'en est jamais qu'un élément parmi d'autres. C'est l'objet du chapitre 11 qui s'intéresse à la Stratégie nationale antidrogues qui a eu cours au Canada entre 1987 et 1997. Il convient d'autant plus de s'y arrêter que cette stratégie a été le seul moment dans l'histoire de nos politiques publiques sur les drogues où il a été tenté d'adopter une stratégie globale et intégrée. Le chapitre 12 présente ensuite l'historique de la législation canadienne en matière de drogues illicites jusqu'à celle qui prévaut depuis 1996. Cet historique est important puisqu'il permet de mieux saisir les éléments de continuité et de rupture qui ont pu marquer les discours et les pratiques. Nous consacrons un chapitre spécifique (13) à l'examen de la réglementation de l'accès au cannabis thérapeutique. Les quatre chapitres qui suivent examinent les pratiques des diverses institutions qui mettent en œuvre les politiques publiques en matière de drogues illicites : d'abord les pratiques policières (14) et les pratiques judiciaires (15) qui sont au cœur de l'approche en matière de drogues, puis aux chapitres 16 et 17 les pratiques de prévention et les pratiques de soin. Nous concluons cette troisième partie sur une série de trois observations transversales sur les pratiques, insistant en particulier sur la question de leurs coûts économiques.

La partie IV traite des approches de politiques publiques. En matière de drogues, on ne peut faire l'économie de l'architecture des conventions internationales qui régissent ces substances depuis 1912 ; c'est l'objet du chapitre 19. Mais les pays ont choisi des voies différentes pour répondre aux attentes de la communauté internationale. Le chapitre 20 s'arrête longuement aux politiques publiques mises en œuvre dans sept pays. Enfin, le chapitre 21 est fondamental pour comprendre à la fois les recommandations que nous faisons en même temps que pour faire le pont avec nos principes directeurs. Il y est question des approches de politiques publiques. On y verra en premier lieu que la législation n'épuise pas, tant s'en faut, le champ des politiques publiques de l'État en matière sociale généralement, en matière de drogues illicites en particulier. On y distinguera aussi entre les diverses approches législatives, clarifiant au passage des termes très chargés tels ceux de décriminalisation ou de légalisation. Nous explicitons ensuite les motifs, provenant de la connaissance autant que des principes directeurs et de la lecture que nous faisons des attitudes des Canadiens, qui sous-tendent les choix que nous faisons.

Synthétisant l'ensemble de ces connaissances nous émettons un certain nombre de conclusions et de recommandations qui traduisent la thèse fondamentale qui sous-tend notre rapport. Cette thèse est la suivante : ***dans une société libre et démocratique qui reconnaît fondamentalement mais non exclusivement la primauté du droit comme source de règles normatives, et où la puissance publique doit le plus possible favoriser l'autonomie et conséquemment utiliser avec parcimonie les outils de contrainte, une politique publique sur les substances psychoactives doit s'articuler sur des principes directeurs respectant la vie, la santé, la sécurité et les droits et libertés de chaque individu qui, naturellement et légitimement, recherche son bien-être et son épanouissement, et a la capacité de reconnaître la présence, la différence et l'équivalence de l'autre.***

Nous sommes conscients, tout autant qu'au début de nos travaux, qu'il n'existe pas de consensus préétabli dans la société canadienne sur les choix de politiques publiques en matière de cannabis. En fait, nous avons constaté qu'il y a peu de sociétés où existe un consensus largement partagé dans la population et entre la population et les décideurs. Nous sommes conscients, plus encore peut-être qu'au début de nos travaux, que la question du cannabis, vue sous l'angle des politiques publiques qui la gouverne, s'inscrit dans un contexte international plus large et que nous ne saurions penser ni agir comme si nous étions isolés. Nous sommes conscients, enfin, que nos propositions bousculeront plusieurs préjugés et rencontreront des résistances. Nous pensons cependant que la société canadienne aura la maturité de les recevoir et de les étudier à leur mérite.

En ce domaine, comme en tant d'autres domaines de politiques publiques, nous disons qu'il faut agir, et que les connaissances accumulées supportent amplement les orientations que nous proposons, mais que le partage des connaissances et le débat public demeurent des conditions essentielles à la vie démocratique.

PARTIE I

ORIENTATIONS GÉNÉRALES

CHAPITRE 1

NOTRE MANDAT

LIBELLÉ

Le 16 avril 2000, suite à une motion déposée par le sénateur Pierre Claude NOLIN, le Sénat adoptait l'ordre de renvoi suivant :

« Qu'un comité spécial du Sénat soit formé afin de réévaluer les lois et les politiques canadiennes antidrogues, de consulter abondamment la population canadienne pour déterminer les besoins spécifiques des différentes régions du pays, plus particulièrement là où les problèmes sociaux liés au trafic et à l'usage de drogues illicites sont plus manifestes, d'élaborer des propositions pour diffuser toute information relative à la politique canadienne antidrogues et, enfin, de produire des recommandations pour en arriver à l'adoption d'une stratégie antidrogues mise au point par et pour les Canadiens encourageant tous les paliers de gouvernement à travailler en étroite collaboration à la réduction des méfaits liés à la consommation de drogues illicites ;

Sans que ce qui suit ait pour effet de restreindre son mandat, que le comité soit autorisé à :

- *Réexaminer l'approche adoptée par le gouvernement fédéral pour combattre la consommation de drogues illicites au Canada, son efficacité comme moyen de réduire les effets de la consommation de stupéfiants et la mesure dans laquelle son application est juste ;*
- *Élaborer une politique nationale de réduction des méfaits afin d'atténuer les impacts négatifs de la consommation de drogues illicites au Canada et faire des recommandations sur la façon d'appliquer cette politique,* **notamment la possibilité de considérer avant tout l'usage et l'abus de drogues comme un problème socio-sanitaire** [1]*;*
- *Étudier les modèles de réduction des méfaits adoptés par d'autres pays et déterminer, s'il y aurait lieu, de les appliquer partiellement ou intégralement, au Canada ;*
- *Examiner le rôle et les obligations internationales qui incombent au Canada en vertu des conventions des Nations Unies sur les stupéfiants, de la Déclaration universelle des droits de l'homme et d'autres traités connexes afin de déterminer si ces traités l'autorisent à prendre des mesures autres que les poursuites criminelles et la pénalisation des contrevenants à l'échelle internationale ;*

[1] En caractère gras dans l'original.

- *Explorer les effets du cannabis sur la santé et étudier la question de savoir si l'emploi de politiques alternatives au sujet de l'usage du cannabis conduirait à une augmentation de l'usage et de l'abus à court et à long terme ;*
- *Étudier la possibilité que le gouvernement use du pouvoir de réglementation que lui confère la Loi sur les contraventions comme moyen supplémentaire d'appliquer une politique de réduction des méfaits comme il est d'usage dans d'autres juridictions ;*
- *Étudier toute autre question relative à la politique canadienne antidrogues que le comité juge appropriés pour accomplir son mandat. »*

Suite à l'adoption de cette motion, le président du Comité a invité le Sénat à désigner les membres qui formeraient le Comité. Furent alors nommés les Sénateurs suivants : Pierre Claude NOLIN, président, Sharon CARSTAIRS, Vice-présidente, Colin KENNY, Lucie PÉPIN et Eileen ROSSITER.

Le Comité ainsi constitué a approuvé un programme de travail et un budget qu'il a ensuite soumis à ses pairs à la Chambre haute. Le budget du Comité a été approuvé en juin 2000 permettant ainsi l'embauche des personnels scientifique et administratif qui le soutiendraient dans ses travaux. Le Comité a organisé son programme d'audiences de témoins experts et tenu ses premières audiences le 16 octobre 2000.

Toutefois, suite au déclenchement des élections générales en octobre 2000, le Comité a été dissous. Il a été reconstitué le 15 mars 2001 mais avec un mandat modifié : en effet, la portée de ses travaux était désormais réduite au cannabis. Le mandat du Comité dans sa forme actuelle se lit donc comme suit :

« Qu'un comité spécial du Sénat soit formé afin de faire rapport sur :

- *l'approche du Canada concernant le chanvre indien (cannabis), ses préparations et dérivés et les préparations synthétiques semblables, en contexte ;*
- *l'efficacité de cette approche, les moyens de sa mise en œuvre ainsi que le contrôle de son application ;*
- *les politiques officielles pertinentes adoptées par d'autres pays ;*
- *le rôle et les obligations internationales qui incombent au Canada en vertu des conventions des Nations Unies sur les stupéfiants relativement au cannabis, de la Déclaration universelle des droits de l'homme et d'autres traités connexes ;*
- *les effets sociaux et sanitaires du cannabis et les effets possibles de politiques différentes ;*

Que le comité spécial soit composé de cinq sénateurs dont trois constituent le quorum ;

Que les honorables sénateurs Banks, Kenny, Nolin et Rossiter (le cinquième membre sera nommé par le whip en chef du gouvernement) soient nommés au comité ;

Que le comité ait le pouvoir de faire comparaître des personnes et produire des documents, d'entendre des témoins, de faire rapport au besoin et de faire imprimer au jour le jour documents, mémoires et témoignages selon les instructions du comité ;

Que les mémoires reçus et les témoignages entendus lors de l'examen du projet de loi C-8, Loi portant sur la réglementation de certaines drogues et de leurs précurseurs ainsi que d'autres

substances, modifiant certaines lois et abrogeant la Loi sur les stupéfiants en conséquence par le Comité sénatorial permanent des affaires juridiques et constitutionnelles durant la deuxième session de la trente-cinquième législature, soient envoyés au comité ;
Que les documents et les témoignages recueillis sur le sujet par le Comité spécial sur les drogues illicites du Sénat durant la deuxième session de la trente-sixième législature soient envoyés au comité ;
Que le comité soit habilité à autoriser, s'il le juge opportun, la radiodiffusion, la télédiffusion et la diffusion par les médias électroniques de la totalité ou d'une partie de ses délibérations et des informations qu'il détient ;
Que le comité présente son rapport final au plus tard le 31 août 2002 et qu'il conserve les pouvoirs nécessaires à la diffusion de ses constatations pendant trente jours après le dépôt de son rapport ;
Que le comité soit autorisé, indépendamment de l'usage habituel, à déposer son rapport auprès du greffier du Sénat si le Sénat ne siège pas, et que le rapport soit réputé avoir été déposé au Sénat. »

ORIGINES

Le mandat dévolu au Comité s'inscrit dans l'historique de la législation adoptée en 1996 par le Parlement du Canada en matière de drogues, la *Loi réglementant certaines drogues et autres substances.* Cette législation, refondant les lois sur les drogues au Canada et abrogeant la *Loi sur les stupéfiants* et certains articles de la *Loi sur les aliments et drogues*, s'inscrit elle-même dans une histoire relativement longue dont nous donnerons ici un bref aperçu puisque le chapitre 12 est consacré à l'historique détaillé des lois sur les drogues au Canada.

Le projet de loi C-7 déposé en première lecture par le gouvernement libéral nouvellement élu en février 1994 proposait de refondre la législation en matière de drogues illicites, afin notamment de lui donner une plus grande cohérence et de rendre la législation nationale conforme aux obligations du Canada relativement à la *Convention des Nations Unies contre le trafic illégal des stupéfiants et d'autres substances psychotropes* signée en 1988. Ce projet a franchi toutes les étapes jusqu'à la troisième lecture en octobre 1995. Suite à la prorogation de la 1ère session de la 35e législature, il a été réintroduit à la Chambre des Communes au début de la 2e session, le 6 mars 1996, sous le nom de C-8. Il a été adopté la même journée et renvoyé au Comité sénatorial permanent des affaires juridiques et constitutionnelles qui en a fait une lecture détaillée et entendu plusieurs témoins. Le projet de loi C-8 a été adopté et a reçu la sanction royale le 20 juin 1996. Il s'agit donc de la législation en vigueur actuellement au pays en matière de drogues illicites.

Lors des travaux, en 1994 et 1995, du Sous-comité sur le projet de loi C-7 du Comité permanent de la Santé de la Chambre des Communes, «*l'immense majorité des témoins (...) se sont montrés très critiques envers le projet de loi. Les critiques les plus générales*

portaient sur trois points : d'abord le manque de principes de base ou d'un énoncé explicite sur le but de la loi ; ensuite, le fait que le projet de loi suivait le système de prohibition des années 20, codifié par la suite dans la Loi sur les stupéfiants ; enfin, l'absence d'une insistance sur les critères de réduction des dommages et de prévention qui sont à la base de la Stratégie canadienne antidrogues. »[2] Malgré les amendements apportés par le sous-comité de la Chambre, les témoignages des personnes entendues par le Comité du Sénat ont été tout aussi critiques. Les témoins ont fait observer que la loi ne catégorise pas les drogues selon leurs dangers, qu'elle ne comporte pas de critères précis et rationnels, ou qu'il était impossible, notamment au vu de la complexité de la loi, de savoir comment elle serait appliquée dans la pratique.

L'ensemble de ces critiques avait mené le Comité sénatorial à *« proposer énergiquement »* la création d'un Comité mixte de la Chambre des Communes et du Sénat qui examinerait toutes les lois, politiques et programmes canadiens antidrogues.[3]

Les élections fédérales de 1997 ont toutefois coupé court à cette demande. Le sénateur NOLIN, convaincu de la nécessité d'agir, et devant l'inaction de la Chambre des Communes, a donc déposé sa première motion en 1999 pour que soit créé un Comité du Sénat ayant pour mandat d'examiner les lois, politiques et programmes sur les drogues illicites au Canada. Cette motion a suivi son cours jusqu'à son adoption par le Sénat en avril 2000.

Pour appuyer cette motion, le Sénateur NOLIN avait alors fait préparer par la Dr Diane Riley une étude sur la politique canadienne de contrôle des drogues. Cette étude visait notamment à « *aider à analyser la politique de contrôle de l'utilisation des stupéfiants sous un jour nouveau, sans se laisser influencer par les préjugés souvent non fondés que la société canadienne entretient vis-à-vis des toxicomanes.* »[4] Le sénateur NOLIN y écrivait encore qu'un Comité spécial du Sénat

> *« serait chargé, dans un premier temps, de transmettre à la population canadienne une information précise et objective sur l'utilisation des drogues illégales, leurs effets sur les individus et la société et les mesures de contrôle en place. Dans un deuxième temps, il pourrait mener des consultations sur les modifications souhaitables que le Parlement devrait apporter à la législation sur le contrôle de l'utilisation des drogues dans les années qui viennent. »*[5]

---

[2] Allain, J. (1997) *Projet de loi C-8 : Loi réglementant certaines drogues et autres substances.* Ottawa : Bibliothèque du Parlement, page 35.

[3] Comité sénatorial permanent des affaires juridiques et constitutionnelles, Onzième rapport, juin 1996, page 8.

[4] Nolin, P.C. (1998) Préface. In Riley, D., (1998) *La politique canadienne de contrôle des drogues. Aperçu et commentaires.* Ottawa, page 10.

[5] *Ibid.*, page 11.

NOTRE COMPRÉHENSION

Notre mandat comporte quatre composantes essentielles et incontournables :

1. Examiner l'approche en matière de cannabis, les moyens de sa mise en œuvre, les modalités de contrôle et son efficacité ;
2. Examiner les politiques et approches suivies dans d'autres pays ;
3. Examiner les implications des conventions et traités internationaux ; et
4. Examiner les effets sociaux et sanitaires du cannabis et les effets possibles de politiques différentes.

Nous avons choisi d'interpréter notre mandat de la manière la plus large possible. Certains nous ont demandé si nous avions l'ambition d'être une Commission Le Dain[6] bis. D'autres nous ont dit que nous n'avions pas les moyens de notre volonté d'être aussi exhaustifs et rigoureux. D'autres encore ont regretté le « saucissonnage » qui nous a limités, dans cette première phase de nos travaux, au cannabis, comme si l'on pouvait séparer ainsi les diverses substances et classifier les usagers en conséquence.

Le chapitre suivant, sur notre programme de travail, démontrera clairement que nous avons été animés par une ambition de rigueur et le désir d'embrasser large. Néanmoins, nous sommes conscients de la portée et des limites de notre rôle de Comité sénatorial. D'autant plus conscients d'ailleurs que les moyens mis à notre disposition étaient aussi restreints que notre ambition était généreuse.

La question du découpage entre les substances est plus problématique, pour diverses raisons. Premièrement, des travaux récents démontrent qu'il est plus important de distinguer entre les conduites des usagers qu'entre les substances. Selon cette perspective, ce ne sont donc pas tant les drogues elles-mêmes qu'il convient de distinguer que les manières différentielles de les consommer et les milieux dans lesquels s'inscrivent ces usages, et par là les risques que courent un certain nombre d'usagers. On parlera ici de conduites à risque[7] qui ne tiennent pas tant des caractéristiques des substances que de celles des usagers et des conditions dans lesquelles se font les usages. Deuxièmement, les distinctions entre substances ne reposent pas sur des bases scientifiques claires. Ainsi, selon qu'on considère les propriétés pharmacologiques des diverses drogues, leurs effets sur la santé physique ou leur origine et leurs modes de culture, on arrive à des classifications entièrement différentes. Et troisièmement, ce découpage entre substances ne permet pas de proposer une politique globale et intégrée sur les drogues.

---

[6] La Commission Le Dain a enquêté sur les drogues illicites au début des années 1970. Il en sera plus amplement question au chapitre 12. Voir : Canada (1970) *Rapport provisoire de la Commission d'enquête sur l'usage des drogues à des fins non médicales.* (Commission Le Dain) Ottawa : Imprimeur de la Reine.

[7] Sur cette question voir notamment les travaux des professeurs Parquet et Reynaud, notamment Reynaud, M., P.J. Parquet et G. Lagrue (1999) *Les pratiques addictives. Usage, usage nocif et dépendance aux substances psychoactives.* Rapport préparé à la demande du Directeur général de la Santé. Paris : Secrétariat d'État à la Santé et aux Affaires Sociales.

Par ailleurs, ce découpage qui nous a fait limiter nos travaux au cannabis n'a pas que des inconvénients et des limites. Avouons d'abord qu'embrasser l'ensemble du champ des drogues illicites d'un seul coup avec si peu de moyens relevait du tour de force. De plus, des commissions d'enquête récentes et des conférences scientifiques internationales ont choisi de faire le point, comme nous, sur l'état des connaissances en matière de cannabis. Nous pouvions donc à la fois nous servir de leurs travaux et les comparer aux nôtres. Enfin, et surtout, des expériences menées dans d'autres pays, notamment aux Pays-Bas, montrent tout le mérite qu'il peut y avoir à traiter le cannabis séparément, dans une approche de « séparation des marchés ».

En somme, tout en restreignant nos travaux au domaine du cannabis, nous avons toujours invité les témoins entendus à ne pas se limiter à cette seule substance et à nous montrer les liens entre elles et entre les divers comportements à risque des usagers lorsqu'ils se présentent. Nous avons aussi gardé en mémoire la nécessité d'aborder les drogues dans une politique intégrée, notamment lorsqu'il est question des grands paramètres d'une politique publique, législation ou infrastructure de connaissance par exemple.

CHAPITRE 2

NOS TRAVAUX

Concevoir, élaborer, implanter une politique publique, est au cœur même de la chose publique, de la vie politique au sens fort. Ce geste fondamental suppose de choisir entre diverses alternatives et, en démocratie, d'expliquer et de justifier le choix qui est fait. Or, une politique publique, quel que soit son objet, est au confluent d'influences diverses : des considérations de politique partisane bien sûr, des considérations économiques aussi et même de plus en plus. Mais si tant est qu'elle prétende à une certaine rationalité et à l'adhésion des citoyens, une politique publique doit aussi s'appuyer sur des données objectives et rigoureuses, préférablement des données émanant de la recherche scientifique, ainsi que sur une compréhension des attentes et des résistances de la société. Enfin, une politique publique devrait, selon nous prendre appui sur, et en même temps promouvoir, des principes directeurs. Nous entendons par là une vision claire et explicite des principes qui président au choix entre diverses alternatives et qui traduisent une conception du gouvernement et de la relation entre les institutions de l'État et la société civile.

Notre Comité a choisi, dès le départ, de rester au-dessus des questions partisanes. C'est là tout l'avantage d'appartenir au Sénat, qui permet de porter, sur diverses questions, un regard plus distancié, qui n'est pas à la solde des intérêts reliés à la réélection. Quant aux considérations d'ordre économique, elles nous ont affectés de deux manières différentes. La première, banale, relève des budgets qui nous étaient alloués et qui limitaient nécessairement la portée de nos travaux. La seconde manière tient aux impacts économiques de diverses options de politique publique, dont il sera question aux chapitres 18 et 21.

Nos travaux se sont donc centrés sur les trois autres sources qui devraient influencer un choix de politique publique en matière de drogues illégales, soit la connaissance, l'opinion publique et les principes directeurs.

Lors des audiences publiques du Comité, le président présentait ainsi le programme de travail :

> *« Afin de remplir adéquatement le mandat qui lui est confié, le comité a adopté un plan d'action. Ce plan s'articule autour de trois enjeux dont le premier est celui de la connaissance. Nous entendrons une gamme importante d'experts, tant Canadiens qu'étrangers, des milieux académiques, policiers, judiciaires, médicaux, gouvernementaux et sociaux. (...)*

Le deuxième enjeu, sûrement le plus noble, est le partage de la connaissance. Le comité désire que les Canadiens de partout s'informent et partagent l'information que nous aurons recueillie. Afin de réaliser cet enjeu, nous assurerons l'accessibilité et la distribution de cette connaissance. Nous voudrons également connaître les vues de la population sur celle-ci et pour ce faire nous tiendrons au printemps 2002 des audiences publiques à différents endroits au Canada.
Enfin, comme troisième enjeu, le comité voudra examiner quels sont les principes directeurs sur lesquels une politique publique canadienne sur les drogues doit s'appuyer. » [1]

Ce chapitre décrit les diverses actions que nous avons entreprises pour cerner l'état des connaissances et de l'opinion publique sur le cannabis et déterminer des principes directeurs. Le chapitre suivant présentera en détail nos principes directeurs, tandis que les parties II et III présentent l'ensemble des connaissances que nous avons pu recueillir. Mais d'abord quelques mots sur deux principes de travail qui nous sont apparus essentiels à la pleine réalisation du mandat de ce Comité.

DEUX PRINCIPES DE TRAVAIL

Tenant compte de l'énoncé de notre mandat qui incluait l'obligation de fournir aux Canadiens une information juste et rigoureuse, nous avons insisté, tout au long de nos travaux, sur la rigueur et la transparence.

Mener nos travaux de manière rigoureuse était d'autant plus impératif qu'en matière de drogues illicites, les opinions des uns et des autres sont fortes, souvent tranchées. Comme chacun d'entre vous, nous avions, nous aussi, nos opinions et nos conceptions sur les drogues illicites au début de nos travaux. Comment pourrait-il en être autrement ? Comme vous, nous avons des enfants. Comme vous, nous avons connu des amis, des parents, dont la vie a été chavirée par des problèmes de toxicomanie. L'étude que nous avions faite du projet de loi du gouvernement et qui nous avait donné la chance d'entendre un certain nombre d'intervenants et d'experts nous avait alimentés d'informations certes, mais avait aussi laissé voir les carences importantes de notre savoir. Il nous était apparu alors plus clairement que les opinions étaient souvent basées sur des informations partielles, parfois fausses. Sur quelle base affirmer que le cannabis mène à l'usage d'autres drogues ? Quelles sont les assises des conceptions de la dépendance ? Quelle est réellement la marge de manœuvre d'une nation face aux dispositions des conventions internationales régissant la production, le trafic, et la possession de drogues illicites ?

On ne peut affirmer une chose et son contraire. Or, en matière de drogues, et spécifiquement en matière de cannabis, c'est bien là ce qu'il nous était donné d'entendre, et avec conviction. Comment déterminer qui avait raison ? Et démêler les opinions des faits ?

---

[1] Sénat du Canada (2001) *Délibérations du Comité spécial sur les drogues illicites.* Fascicule no 1, page 23.

Ces constats nous ont convaincus que la plus grande rigueur s'imposait au cours de nos travaux. Mais il ne suffisait pas d'être rigoureux. Pour que cette information atteigne les Canadiens, il fallait qu'elle ne soit pas réservée à notre usage exclusif. D'où le second principe qui nous a guidés : la transparence. Dès le départ en effet, nous avons insisté pour que tous nos travaux soient le plus rapidement possible rendus disponibles sur notre site internet. Pour les audiences de témoins experts, rien là de neuf puisqu'il est de pratique courante pour la plupart des Comités parlementaires d'agir ainsi. Mais en plus de ces témoignages, nous avons commandé un certain nombre d'études, notamment auprès de Division de la recherche parlementaire de la bibliothèque du Parlement. Nous avons insisté et obtenu que ces études, souvent rendues publiques seulement après la publication du rapport du comité, soient mises à la disposition des Canadiens au fur et à mesure.

Législateurs, nous souhaitons bien entendu que nos travaux aient un impact sur les politiques publiques. Nous pensons qu'il est au moins aussi essentiel de fournir aux citoyens du pays une information que nous pensons la plus rigoureuse possible, afin qu'ils puissent en bénéficier.

L'ÉTAT DES CONNAISSANCES

Lorsque la Commission royale d'enquête sur l'usage des drogues à des fins non médicales a mené ses travaux au début des années 1970, elle disposait, comme la majorité des commissions d'enquête, d'un personnel et de budgets importants lui permettant de mener un vaste programme de recherche. C'était d'autant plus nécessaire qu'il n'existait pas encore, à cette époque, un large bassin de connaissances sur les drogues illicites. On ne savait à peu près rien des principes actifs du cannabis et même des propriétés pharmacologiques des drogues plus traditionnelles comme l'héroïne et la cocaïne, on connaissait peu de choses sur les trajectoires des usagers, les études criminologiques sur la relation entre drogues et criminalité étaient pour ainsi dire inexistantes et les études d'impact des politiques publiques en étaient à leurs tout débuts.

Dire que la situation a changé du tout au tout serait un euphémisme. Dans l'ensemble des disciplines scientifiques, depuis la biologie moléculaire jusqu'à l'anthropologie, on ne compte plus le nombre d'études qui ont été menées au cours des vingt-cinq dernières années sur les drogues illicites en général, sur le cannabis en particulier. Elles proviennent des États-Unis, mais aussi d'Allemagne, d'Australie, du Canada, du Danemark, de Finlande, de France, d'Italie, du Royaume-Uni, de Suède et de Suisse… Elles ont été menées par des universitaires s'intéressant à ces questions sur un plan purement individuel, par des laboratoires pharmacologiques, par des regroupements de chercheurs au sein d'organismes oeuvrant dans le domaine des

toxicomanies, et dans le cadre de commissions scientifiques nommées par des gouvernements de divers pays.

Le Comité a d'ailleurs commandé à la Bibliothèque de Parlement un inventaire des recherches en cours ou complétées depuis les cinq dernières années au fédéral et dans les provinces et territoires sur les drogues illicites.[2] Cet inventaire, qui n'a aucune prétention à être exhaustif offre plutôt un panorama de l'étendue et de la portée des recherches, démontre à l'évidence que, malgré des budgets lilliputiens comparativement à ce qu'y consacrent les USA, la recherche sur les drogues se porte relativement bien au pays. Quant à faire l'inventaire des études en cours aux USA sur la question des drogues illicites, nous pouvons seulement imaginer que ce serait là une tâche colossale.

Cerner l'état des connaissances signifiait donc en tout premier lieu de se donner les moyens d'en faire une synthèse rigoureuse. Pour ce faire, le Comité s'est donné un programme de recherche portant sur l'ensemble des aspects. Mais n'ayant pas les moyens financiers de produire une vaste série d'études, et souhaitant aussi assurer une transmission large de l'information au public, le Comité a conçu un programme d'audiences publiques de témoins experts susceptibles de contribuer en même temps à mieux cerner l'état des connaissances.

Le Comité a approuvé un programme de travail portant sur cinq grands axes de connaissance se déclinant chacun en questions spécifiques :

- *Aspects socio-historiques, géopolitiques, anthropologiques, criminologiques et économiques de la consommation et de la réglementation du cannabis.* Cette première série de questions permet de situer le contexte et de saisir les pratiques contemporaines en matière de production et d'usage. Les principales questions sont :
  - Quel est l'historique du cannabis, sa production, sa consommation, les modalités de son usage ?
  - Y a-t-il une relation entre l'usage du cannabis et des pratiques religieuses ou culturelles ?
  - Quelle est la relation entre la production, la consommation et l'usage des drogues et les caractéristiques socio-démographiques des populations ? Plus spécifiquement, que sait-on des usagers de cannabis ?
  - Quelles sont les routes des drogues et comment sont-elles reliées aux situations politiques nationales et internationales ?
  - Quelles sont les relations entre les diverses drogues et comment en est-on arrivé à distinguer entre drogues licites et illicites ?

---

[2] Leduc, D., Miller-Chenier, N. et S. Norris (2001) *Inventaire de la recherche fédérale sur les drogues illicites et les questions connexes.* Ottawa : Bibliothèque du parlement, et Miller Chenier, N. et S. Norris (2002) *Inventaire de la recherche provinciale et territoriale sur les drogues illicites et les questions connexes. Ottawa : Bibliothèque du Parlement.* Rapports préparés pour le Comité spécial du Sénat sur les drogues illicites, disponibles en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp

- Quelle est la relation entre production, consommation et réglementation des drogues et criminalité ?
- Quels sont les aspects économiques de l'usage, la production, la consommation et la réglementation du cannabis ?

- *Aspects médicaux et pharmacologiques de la consommation et de la réglementation du cannabis.* L'utilisation du cannabis à des fins médicales occupe actuellement une place importante dans le débat sur les régimes réglementaires le régissant. Il s'agit ici de faire le point sur l'état de la recherche médicale et sur les connaissances quant aux effets physiologiques et psychologiques des diverses drogues. Les principales questions sont :
    - Quelles sont les diverses formes d'utilisation du cannabis à des fins médicales ?
    - Quel est l'état des connaissances quant aux propriétés thérapeutiques du cannabis ?
    - Que connaît-on quant aux effets physiologiques du cannabis, notamment la tolérance et l'accoutumance ?
    - Quel est l'état des connaissances quant aux effets psychologiques du cannabis, notamment la dépendance ?
    - Quel est l'état des connaissances quant aux diverses formes de traitement des dépendances, leurs effets, leurs impacts et leurs coûts ?

- *Aspects juridiques en droit national en matière de cannabis.* La réglementation et le contrôle des drogues au sein des frontières canadiennes repose sur un dispositif législatif fédéral, même si, pour les aspects relatifs au traitement par exemple, la responsabilité relève des provinces et des territoires. Au delà du droit positif, les tribunaux ont proposé des interprétations des lois et réglementations pertinentes, notamment en matière de pouvoirs policiers. Invoquant les disciplines du droit, de l'histoire, de la sociologie, et de la criminologie, il conviendra de faire le point sur l'origine et les évolutions de ce dispositif. Les principales questions guidant ce troisième volet du programme de recherche sont :
    - Quel est l'historique des modes de réglementation et de contrôle du cannabis ?
    - Comment a évolué sa pénalisation ?
    - Quel est l'état de la jurisprudence nationale quant à la validité des lois et règlements qui régissent et contrôlent la production, la consommation, la possession et l'échange de cannabis ?
    - Quel est l'état de la jurisprudence interne quant aux modes d'enquête et aux sentences ?

- Quels sont les effets de la criminalisation du cannabis, notamment sur le système de justice, les institutions carcérales et les trajectoires délinquantes ?
- Quels sont les coûts économiques et sociaux de ces modes de réglementation, de contrôle et de pénalisation ?
- Quelles sont les relations entre les politiques et législations de justice et les politiques de santé publique ?

- *Aspects juridiques internationaux de la réglementation des drogues illicites et du cannabis.* Le Canada est signataire d'un certain nombre de traités et de conventions balisant la production, le trafic et la possession des substances psychoactives. Il nous fallait déterminer dans quelle mesure ces instruments sont contraignants sur la législation nationale. De plus, ces traités et conventions s'inscrivent dans le contexte plus large d'autres instruments internationaux, notamment les conventions et traités qui définissent et garantissent les droits fondamentaux des personnes; il convenait d'examiner leurs interrelations. Enfin, les drogues sont un enjeu des relations internationales et notamment des relations entre le Canada et les États-Unis. Quoique non contraignants sur un plan juridique, ces éléments peuvent influencer sur les orientations des politiques et méritent, en ce sens, d'être explorés. Les principales questions sont :
    - Quels sont les principaux traités et conventions concernant les drogues, leur histoire et leurs dispositions ?
    - Quelles sont les contraintes que ces conventions et traités imposent au Canada ?
    - Au delà des traités et conventions, quels éléments du contexte des relations internationales pèsent sur les choix de politiques internes au Canada en matière de contrôle et réglementation des drogues ?
    - Quels sont les modèles de contrôle et réglementation des drogues en vigueur dans divers pays, quels en sont les impacts, et dans quelle mesure pourraient-ils s'appliquer au Canada ?

- *Aspects éthiques et opinions et normes de conduite des Canadiens.* Les choix de politiques et orientations législatives en matière de drogues sont aussi guidés par des considérations d'ordre éthique et moral et par les normes auxquelles adhèrent les Canadiens. Les principales questions sont :
    - Quelles sont les considérations éthiques pertinentes au choix des orientations politiques et juridiques quant à la consommation, à la production, à la possession et à la circulation des drogues ?
    - Quelles sont les considérations éthiques pertinentes en matière d'usage thérapeutique du cannabis et de traitement médical et psychologique des dépendances ?

- Quel est l'état des normes de comportement des Canadiens en matière de cannabis ?
- Quel est l'état des opinions et normes de tolérance des Canadiens?
- Quel degré de correspondance existe-t-il entre les considérations éthiques et les normes de tolérance des Canadiens?

Vaste programme, on le voit. Pour tenter de répondre à ces questions de la manière la plus efficace en même temps que la plus économique possible, le Comité a convenu de mener deux tâches de front : un programme de recherche et un programme d'audiences de témoins experts devant se compléter mutuellement.

Le programme de recherche

Ne disposant ni de budgets de recherche nous permettant de commander des études ni d'un personnel de recherche à plein temps, nous avons demandé à la Bibliothèque du Parlement de produire des synthèses de la littérature pertinente.[3] Ces travaux se déclinent en trois grandes catégories :

- Des études à caractère juridique : analyses de la jurisprudence nationale et des conventions et traités internationaux ;
- Des études à caractère socio-criminologique : analyses de la relation entre drogues et criminalité ; de l'évolution des dénonciations, des mises en accusation et des sentences ; des pratiques de consommation de cannabis ; des aspects économiques des drogues ;
- Des études comparatives : synthèse des politiques publiques dans certains pays.

De plus, nous avons bénéficié d'une synthèse des connaissances sur les impacts physiologiques et psychologiques du cannabis.[4] Enfin, nous avons pu faire produire une étude qualitative des opinions et attitudes des Canadiens par une firme professionnelle d'enquêtes publiques.[5]

---

[3] On trouvera la liste complète des études produites par la Bibliothèque du Parlement à l'Annexe 3. Tous les rapports de recherche, y incluant ceux qui sont mentionnés infra aux notes 6 et 7 sont disponibles en ligne à l'adresse Internet du Comité : www.parl.gc.ca/drogues-illicites.asp. Le Comité souhaite exprimer ici son appréciation la plus vive quant aux travaux réalisés pour lui par la Division de la recherche de la Bibliothèque du Parlement.

[4] Wheelock, B. (2002) *Les impacts physiologiques et psychologiques du cannabis : une synthèse de la littérature.* Ottawa : Sénat du Canada. Rapport préparé pour le Comité spécial du Sénat sur les drogues illicites. (Le Comité tient ici à remercier tout particulièrement la Sénatrice Rossiter qui a rendu possible la préparation de ce travail.). Disponible en ligne à l'adresse www.parl.gc.ca/drogues-illicites.asp

[5] Léger Marketing (2002) *Étude exploratoire auprès des Canadiens sur l'usage du cannabis.* Ottawa : Sénat du Canada. Rapport préparé pour le Comité spécial du Sénat sur les drogues illicites. Disponible en ligne à l'adresse www.parl.gc.ca/drogues-illicites.asp

Au total, le Comité a ainsi obtenu 23 rapports d'étude et a bénéficié de comptes-rendus de travaux menés dans d'autres pays, notamment par le biais de la participation à des conférences internationales.

Audiences de témoins experts

Conscients des limites du programme de recherche, mais surtout de la nécessité d'interroger de vive voix certains des chercheurs dont les travaux étaient cités dans les études réalisées et de confronter leurs analyses entre elles et avec les positions d'autres organismes experts (les forces policières par exemple), nous avons mené une série d'audiences de témoins experts à Ottawa ainsi que dans certaines villes à travers le pays.[6]

Les audiences ont commencé le 16 octobre 2000 sous le 36e Parlement et ont repris le 30 avril 2001 sous le 37e. Elles ont pris fin le 10 juin 2002 par l'audience à Ottawa des principaux ministères responsables des politiques sur les drogues illicites au Canada. Dans la mesure du possible, le Comité a maintenu un rythme soutenu d'audiences, soit à toutes les deux semaines.

Dans chaque cas, le Comité demandait aux témoins de préparer un texte écrit répondant à des questions factuelles spécifiques. En effet, le Comité n'attendait pas des experts qu'ils lui donnent leurs opinions, ni qu'ils lui disent quoi penser. Les audiences de témoins experts s'inscrivaient en effet dans la logique d'une démarche de connaissance. Sachant que notre capacité à mener des études était limitée et reconnaissant que les données issues de la recherche étaient incomplètes, sinon contradictoires, nous voulions profiter pleinement de cette occasion exceptionnelle de clarifier, et de faire mieux connaître, un certain nombre d'éléments de connaissance.

Qui étaient ces experts ? Comment le Comité les a-t-il choisis ? Ces questions sont importantes dans la mesure où un certain nombre d'intervenants ont questionné la crédibilité du Comité en raison précisément de certains des choix qu'il a faits. Premièrement, nous avons tenu à couvrir chacun des grands domaines d'interrogation. Nous avons donc entendu des sociologues et des juristes, des psychologues et des médecins, des policiers et des criminologues. Deuxièmement, nous voulions entendre le plus grand nombre possible d'experts canadiens provenant de ces divers horizons de recherche. Troisième critère, nous avons retenu principalement des experts reconnus pour leurs publications dans le domaine. Des chercheurs tels les professeurs Harold Kallant ou Marie-Andrée Bertrand qui avaient été associés de près aux travaux de la Commission Le Dain il y a trente ans ; des chercheurs associés de près aux grands instituts que sont le *Centre on Mental Health and Addiction* de l'Ontario (anciennement *Addiction Research Foundation*) ou au Centre canadien de lutte à l'alcoolisme et à la toxicomanie. Enfin, des experts qui pouvaient, dans certains cas, parler au nom de

---

[6] On trouvera la liste complète des témoins entendus, les sujets, les lieux et les dates à l'Annexe 2. Tous les témoignages et certains documents complémentaires que nous fournissaient les témoins sont disponibles en ligne à l'adresse du Comité www.parl.gc.ca/drogues-illicites.asp.

grandes institutions : l'Association médicale canadienne, la Fédération canadienne des municipalités, l'Association canadienne des Chefs de Police ou la Gendarmerie royale du Canada. Si l'on regarde attentivement la liste des experts entendus et les objets de leurs présentations, on s'apercevra qu'ils correspondent étroitement à l'ensemble de nos champs de préoccupation.

Lorsque les audiences portaient sur la situation dans d'autres pays, nous avons cherché un équilibre entre les personnes capables de décrire la politique publique et des chercheurs dont les travaux étaient reconnus dans leur pays voire internationalement. La durée et le nombre de nos audiences étant limités, nous avons du faire des choix. Au mieux, nous pouvions entendre quatre personnes. Règle générale, nous avons tenté de choisir un haut responsable de l'administration et trois chercheurs.

De même, on pourra questionner le choix des pays auditionnés : France, Pays-Bas, Suisse. Nous avions initialement prévu d'auditionner le Royaume-Uni, notamment parce que ses politiques publiques en matière de drogues ont fait l'objet de nombreuses études de grande qualité. Malheureusement, les modifications en cours de préparation dans ce pays ont empêché de tenir ces audiences. De même, nous avons manqué de temps pour entendre la Suède ainsi que l'Australie. Par contre, nous avons tout de même fait préparer sur chacun de ces pays des documents de synthèse par la Bibliothèque du Parlement.

Le cas des États-Unis mérite quelque attention. Le chapitre 20 décrit la politique américaine en matière de drogues. Toutefois, nos audiences sur notre grand voisin, beaucoup plus complexe et moins monolithique qu'on ne le pense souvent, ne nous ont pas permis d'entendre les responsables de l'administration américaine. Ce n'est pas faute d'avoir essayé de le faire. Mais soit comme dans le cas du directeur du très prestigieux *National Institute on Drug Abuse* (NIDA) il a remis sa démission la semaine précédant la date prévue des audiences après avoir accepté notre invitation, soit comme dans le cas du Directeur du *Office of National Drug Control Policy* à Washington, il a décliné notre invitation. Bref, nous demeurons insatisfaits de n'avoir pu entendre les hauts fonctionnaires responsables des politiques sur les drogues aux USA. Néanmoins, le 10 juin 2002 nous avons pu rencontrer, en audience privée, M. G.R. Hanson le nouveau directeur du NIDA, et le 11 juin, nous avons reçu à huis-clos M. Walters, le Conseiller national sur les drogues de la Maison-Blanche, et quelques membres de son équipe.

Au total, que ce soit à Ottawa ou dans les villes canadiennes, le Comité a tenu plus de quarante jours d'audiences publiques, entendant plus d'une centaine de personnes de tous les horizons.

Une note encore. On pourra dire que nous n'avons pas traité de la même manière les témoignages des experts de la recherche et ceux de la pratique. C'est vrai pour partie. En effet, dans la mesure où les chercheurs présentaient des données se prêtant à un examen critique, des données vérifiables ce qui ne signifie pas qu'elles soient pour autant des preuves, portant sur des sujets précis, et permettant de répondre peu à peu à nos interrogations empiriques, nous leur avons accordé une importance certaine qui sera reflétée dans les citations qui émailleront ce rapport. Les données de la pratique ne

sont pas, en soi, moins significatives ni importantes à nos yeux. Par contre, les praticiens avaient souvent davantage tendance à exprimer des opinions plutôt qu'à faire état de données d'études. De plus, ils n'avaient pas la même préoccupation de répondre de manière précise aux questions qui leur étaient adressées. Ces opinions sont importantes, comme le sont celles des Canadiens que nous avons entendus et qui nous ont écrit. Ce sont néanmoins des opinions, non des données systématiques et rigoureuses.

Le défi de la synthèse

Devant cette masse d'informations, le plus grand défi demeurait celui de la synthèse. La littérature scientifique sur n'importe lequel des sujets abordés, notamment ceux qui ont trait aux effets du cannabis ainsi qu'aux usagers et aux modes d'usage, est abondante. Les experts nous ont fait état de leurs recherches et de celles d'autres chercheurs. Les rapports préparés à notre demande sont truffés d'informations. Et notre équipe de recherche s'est tenue à l'affût des publications récentes et a participé à diverses conférences scientifiques internationales. Bref, il s'agissait de faire sens de toute cette information, une information de surcroît parfois contradictoire.

Au même moment, sur certains sujets, tels les tendances d'usage du cannabis et des autres drogues au Canada (chapitre 6), ou sur la spécificité des applications thérapeutiques du cannabis qui ne dépasse souvent pas le niveau de l'anecdote (chapitre 9), ou tout platement sur les pratiques policières (chapitre 14) et les décisions des tribunaux du pays (chapitre 15), les données demeurent encore fragmentaires.

Synthèse donc qui signifie aussi faire des choix. Tout en demeurant le plus respectueux de la diversité des perspectives, nous devions tout de même dégager des conclusions. Quitte à accepter que ces conclusions soient préliminaires. Quitte à accepter même qu'elles soient contredites par des recherches ultérieures. C'est bien là le propre du processus de connaissance d'être toujours en mouvement, et nous acceptons cet état de fait. De là, nous sommes conscients que nous nous ouvrons à la critique. Tant mieux pourrions-nous ajouter. D'abord parce que la critique suscitera des débats publics. Ensuite parce qu'elle provoquera sans doute la curiosité de chercheurs qui iront faire la vérification empirique de certaines de nos conclusions, améliorant ainsi l'état du savoir. Et aussi parce que nos choix s'éclairent à la lumière des principes directeurs qui sont explicités au chapitre suivant.

TENIR COMPTE DES OPINIONS

L'opinion publique est chose difficile à saisir. D'abord parce qu'elle n'existe pas en soi mais qu'elle est créée : elle le sera par la manière dont sont posées les questions du sondeur ; elle le sera par la manière dont les médias d'information construisent les contours d'un débat ; elle le sera encore par un contexte plus large de représentations, dont on ne sait jamais exactement quels sont les déterminants réels.

Saisir l'opinion publique sur un sujet complexe comme celui des drogues, ce n'est pas demander le type de lessive qu'on va acheter au supermarché. Une question en apparence simple devient rapidement complexe dès qu'on ouvre la boîte de Pandore. Une enquête d'opinion publique peut demander au public s'il est en faveur de la décriminalisation du cannabis. Soit. Mais sait-on si chacun met la même chose dans le terme décriminalisation ? On verra au chapitre 21 la complexité de ce terme. Sait-on si les répondants sont en faveur ou en défaveur pour les mêmes raisons ? Et une fois qu'on aurait une majorité pour ou contre, sait-on quelles seraient les modalités d'application de ce choix de politique publique ?

Ceci étant, tenir compte de l'opinion est une nécessité en démocratie. En tenir compte signifiait pour nous deux choses étroitement reliées. La première, signifiait un devoir d'information, voire d'éducation. Souhaitons qu'on nous pardonnera le choix de ce terme si l'on y trouve offense. Mais nous sommes convaincus que, sur des sujets de politique publique qui sont des enjeux de société, il est du devoir des responsables politiques de transmettre une information qui fasse œuvre de pédagogie et non simplement de conviction. En matière de drogues illicites, même de cannabis qui est pourtant la drogue la mieux connue, le niveau de connaissances demeure souvent limité et il circule encore beaucoup de mythes. La seconde signification de cette nécessité de tenir compte de l'opinion publique impliquait pour nous d'aller à sa rencontre. Nous y sommes allés de trois manières.

Primo, nous avons fait connaître nos travaux le plus largement possible et de la manière la plus transparente possible pour permettre à tous et chacun d'en prendre connaissance et d'y réagir. Beaucoup ont choisi de le faire en nous écrivant. Évidemment, c'est peu de personnes au regard du nombre de citoyens du pays.

Secundo, nous avons commandé une étude qualitative d'opinion publique. Ces groupes de discussion, menés à travers le pays, seront présentés plus en détail au chapitre 10.

Et tertio, nous avons tenu des audiences publiques dans diverses villes du pays (10 au total), permettant ainsi à un certain nombre de citoyens de venir nous dire ce qu'ils pensaient, ce qu'ils connaissaient, ce qu'ils vivaient.

Informer et aller à la rencontre de l'opinion publique, nous en sommes conscients, c'est aussi contribuer à la former. Ce n'est donc pas un geste neutre.

INTERPRÉTER À LA LUMIÈRE DE PRINCIPES

Toute cette connaissance, celle issue de la recherche aussi bien que celle issue de l'opinion du public, demande encore à être interprétée. Les connaissances scientifiques sont sujettes à vérification constante. Elles sont parfois contradictoires, comme on le verra dans les chapitres 7 et 8 notamment. Quant à la connaissance de l'opinion publique, elle demeure nécessairement fragmentaire et en évolution. De là découle une place importante à l'interprétation.

Au delà, une politique publique, nous l'avons dit plus haut, n'est pas informée que par les connaissances, aussi rigoureuses soient-elles. Il faut des principes directeurs, capables d'informer l'interprétation des données et en même temps de guider le choix des conclusions. C'est l'objet du chapitre suivant, qui présente nos principes et décrit la démarche que nous avons entreprise pour nous donner des principes directeurs.

CHAPITRE 3

NOS PRINCIPES DIRECTEURS

De quoi devrait être faite une politique publique sur les drogues illicites, politique étant entendue ici au sens premier de gouvernement par le débat public et non de politique de partis ? Appartenant au Sénat du Canada, donc au Parlement, et dotés d'un pouvoir législatif, l'on pourrait trouver étrange que nous posions cette question. Ne sommes-nous pas, législateurs, guidés par les principes du bon gouvernement, c'est-à-dire par l'intérêt général ? Pour autant, qu'est-ce que l'intérêt général ? Et comment le déterminer ? Notre position de sénateurs nous confère-t-elle *de facto* une capacité à dire ce qui est ou devrait être l'intérêt de la nation canadienne ? Nous ne le pensons pas.

Devant des enjeux de société comme celui des drogues illicites, nous sommes comme tout un chacun des citoyens, aux prises avec nos croyances, nos connaissances, nos valeurs, nos doutes, nos mythes. Notre accès privilégié à une centaine de témoins experts, la lecture de nombreux rapports de recherche et le dialogue avec des dizaines de citoyens à travers le pays nous ont obligés à confronter nos idées préconçues, nos représentations, à celles des « autres », et sinon à les modifier du moins à les raffiner en cours de route. Mais cela ne suffit pas à déterminer l'intérêt général. Les experts, pas plus que les quelques citoyens entendus, ne forment l'intérêt général de la société. Les études ne révèlent que la partie superficielle de ce que pensent les Canadiens. Et quand des enquêtes sophistiquées nous auraient fourni une lecture approfondie de l'état de l'opinion publique, nous ne serions guère plus avancés pour décider des orientations d'une politique publique sur le cannabis. D'abord parce que le bien collectif ne se décide pas à coup de sondages pour déterminer dans quel sens va l'opinion. Et aussi parce que, comme nos opinions personnelles, l'opinion publique repose sur des informations non vérifiées, sur des préconceptions parfois biaisées, sur des valeurs pas toujours explicitées.

Très souvent, on nous a dit que les choix de politique publique que nous ferons doivent se centrer sur l'avenir des enfants, sur le type de société dans laquelle nous voulons vivre et que nous voulons leur léguer. La société canadienne a mis en place, depuis une vingtaine d'années, des programmes coûteux de prévention du tabagisme ; voudrait-on les contredire en permettant le fumage du cannabis ? Le cannabis est une substance psychoactive qui peut altérer certaines facultés cognitives reliées à l'apprentissage chez les jeunes ; veut-on leur transmettre le message qu'il est ok de consommer des drogues ?

D'autres nous ont dit que les valeurs fondamentales de la société canadienne, valeurs de respect des droits et libertés des personnes, de tolérance et d'ouverture à la diversité étaient compromises par les lois actuelles sur le cannabis. N'étant plus en phase avec la société, traduisant une opposition de générations entre les adultes et les jeunes, ces lois, ont-ils ajouté, entraînent plus de conséquences négatives qu'elles ne concourent au bien commun, et en plus d'être inefficaces elles sont iniques.

Question de valeurs donc, qui oppose diverses conceptions de la santé publique, de la santé d'une collectivité entendue aussi bien au sens de la santé physique des personnes que de la santé de la collectivité tout entière, dans sa fibre morale ainsi que dans les modèles de relation à soi-même et à l'autre qu'elle propose. Mais les valeurs des uns ne sont pas celles des autres.

En ce monde fragmenté, voire désillusionné qui est le nôtre, mais un monde qui est aussi, même si ce n'est pas toujours par choix, un monde ouvert au partage des cultures et des identités, se pose crûment la question des valeurs et par là du sens de la vie en société. Même s'agissant des valeurs transcendantales du respect sacré de la vie et de la justice immanente que nous partageons tous, leur traduction en politiques publiques n'est pas chose immédiate ou simple : pensons ici aux questions de l'avortement ou de la peine capitale. Quant aux autres ordres de valeurs, celles de la liberté, de la vérité, ou du droit, ils sont des enjeux incessants de débats dans les sociétés démocratiques et ce sont précisément ces ordres de valeurs qui sont en jeu dans une politique publique sur les drogues illicites.

Il y a trente ans maintenant, la Commission Royale d'enquête sur l'usage non médical des drogues, la Commission Le Dain du nom de son commissaire principal, a étudié des questions similaires à celles que nous étudions aujourd'hui. Son rapport sur le cannabis, dont les conclusions scientifiques sur ses effets étaient généralement acceptées par tous les commissaires, a néanmoins donné lieu à … trois rapports : un rapport majoritaire de trois commissaires et deux rapports minoritaires. Lors de notre toute première journée d'audiences publiques, la professeure Line Beauchesne nous a présenté ainsi les divergences de fond entre les commissaires :

> *« La différence de leur rapport est essentiellement sur les valeurs sur lesquelles ils forment une politique en matière de drogues. Je vais me servir de ce rapport pour illustrer les trois grandes positions qu'on peut avoir à ce sujet.*
>
> *La première position est celle de Ian Campbell. C'est ce qu'on appelle en droit le moralisme juridique. Une politique publique fondée sur le moralisme juridique en matière de drogue permet de justifier la prohibition actuelle et les répressions qui en découlent au nom de la protection des valeurs communes. (…) Pour la résumer en quelques mots, disons qu'on attribue à l'État la fonction de créer des valeurs communes qu'on va imposer à l'ensemble de la population de manière à créer le maximum d'harmonie sociale possible. Si tout le monde pense pareil, cela crée moins de problèmes.*
>
> *(…)*
>
> *La deuxième position qui était la position dominante de la Commission Le Dain se fonde sur le paternalisme juridique. Une politique publique fondée sur le paternalisme juridique en matière de*

drogues permet de justifier la prohibition actuelle au nom du rôle de l'État en matière de protection des personnes non autonomes, surtout les jeunes.
(...)
Lorsqu'on arrive à la troisième position, celle de Marie-Andrée Bertrand qui demandait la légalisation du cannabis, on arrive aux questions des valeurs (...). Le libéralisme juridique signifie que l'État assume une certaine responsabilité pour maximiser l'autonomie des citoyens. (...) Une politique publique fondée sur le libéralisme juridique en matière de drogues est une approche qui se fonde sur le fait que le rôle de l'État est celui de maximiser la possibilité pour chacun d'être un citoyen à part entière et que l'usage du droit pénal est toujours un échec. » [1]

Moralisme : affirmer des valeurs communes. Paternalisme : protéger les plus faibles. Et libéralisme : maximiser l'autonomie des citoyens. Ces trois catégories n'épuisent pas le champ des possibles : le communautarisme par exemple est une autre approche. Et, à certains moments, dans certains domaines de l'action publique, ces diverses approches peuvent coexister. Néanmoins, chacune d'elles exprime des conceptions divergentes quant au rôle de l'État et du droit pénal, et quant aux rôles de la science et de l'éthique dans les choix qui doivent être faits.

C'est précisément à travers le prisme d'une réflexion sur chacun de ces objets que nous avons choisi de nous donner des **principes directeurs** qui rendent explicites la conception que nous nous faisons du rôle que doivent jouer l'État, le droit pénal, la science et l'éthique dans une politique publique sur le cannabis. Ces principes nous guideront ensuite dans l'analyse que nous ferons des informations issues de la recherche et des pratiques actuelles au Canada, et surtout ils nous influenceront dans nos décisions de recommandations. Ce faisant, les lecteurs bénéficieront de notre tentative de rendre explicites des principes qui demeurent trop souvent implicites, donnant ainsi à chacun la possibilité qui de nous critiquer pour cause d'incohérence, qui d'affirmer son désaccord avec nos conclusions pour cause de non partage de ces principes. Nous pensons que l'exercice a l'avantage de la clarté et de la transparence.

Pour nous aider à la préparation de ces réflexions sur les principes directeurs, nous avons demandé à quatre universitaires canadiens reconnus pour leurs travaux dans leur champ de réflexion et pour leur indépendance, de préparer des documents de réflexion sur chacun des quatre grands enjeux : la gouvernance, le droit pénal, la science et l'éthique.[2] Nous ne saurions trop encourager les Canadiens à lire ces textes d'une

---

[1] Professeure Line Beauchesne, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, deuxième session de la trente-sixième législature, 16 octobre 2000, fascicule1, pages 33-36.

[2] Ce sont : R. Macdonald, professeur de droit constitutionnel et de droit public, Université McGill, *La gouvernance de l'action humaine* ; A.P. Pires, professeur de criminologie, Université d'Ottawa *La politique législative et les crimes à « double face » : Éléments pour une théorie pluridimensionnelle de la loi criminelle* ; T. de Koninck, professeur de philosophie, Université Laval *Le rôle des savoirs et de la culture dans la politique publique sur les drogues illicites* ; et J.F. Malherbe, professeur de travail social, Université du Québec à Montréal, *Contribution de l'éthique à la définition de principes directeurs pour une politique publique sur les drogues illicites.* Ces textes sont accessibles en ligne à : www.parl.gc.ca/drogues-illicites.asp

richesse et d'une qualité exceptionnelles. Pour notre part, nous nous en servirons librement sans avoir la prétention de rendre la complexité de leur pensée ni nous en faire simplement les perroquets. De même que nous ne demandions pas aux témoins de nous dire quoi penser, mais bien de nous faire part, avec le plus de rigueur et d'exactitude possible, de leurs connaissances, qu'elles soient issues de la recherche ou de la pratique, de même nous avons demandé des documents de réflexion et non des réponses à nos questions. Il nous appartient, et c'est ce qui est attendu de nous, de proposer nos propres réponses aux enjeux auxquels les drogues illicites nous confrontent.

Nous débutons par une réflexion sur l'éthique. Nous pensons en effet que la réflexion éthique, en ce qu'elle touche aux fondements mêmes des valeurs, en ce qu'elle impose aussi une exigence de communication et de dialogue[3], constitue la pierre d'assise sur laquelle reposent les autres principes. À cette conception éthique, s'articulent ensuite des principes relatifs à la gouvernance – c'est-à-dire au rôle de l'État – et au droit pénal comme l'un des outils de la réalisation des conditions de vie en société. Nous terminons sur des considérations relatives au rôle de la science, ou plus proprement des savoirs.

L'ÉTHIQUE, OU LE PRINCIPE DE L'AUTONOMIE RÉCIPROQUE

Supposons que la science aurait démontré, statistiques à l'appui, la nocivité de telle drogue – pourquoi pas le tabac – et qu'elle est une « cause » de maladies graves, voire mortelles. Jusqu'où le médecin, le juge, et en bout de piste l'État, sont-ils autorisés à aller pour faire en sorte que les personnes ne fument pas ? Quelle est la limite de l'intervention des uns et des autres ? C'est la question que nous pose l'éthique, spécifiquement ici l'éthique de la «santé ». Devrait-on tout simplement interdire le tabac et punir ceux qui en consommeraient aussi bien que les producteurs ? Devrait-on éduquer à coups de campagnes de prévention ? Devrait-on tenter de dissuader les

---

[3] Voir là-dessus les travaux du sociologue et philosophe allemand Jürgen Habermas, notamment *De l'éthique de la discussion*. Paris : Cerf. L'auteur y présente le processus de discussion éthique comme suit : « Dans les argumentations, les participants doivent partir du fait qu'en principe tous les concernés prennent part, libres et égaux, à une recherche coopérative de la vérité dans laquelle seule peut valoir la force sans contrainte du meilleur argument. La discussion pratique est considérée comme une forme exigeante de formation argumentative de la volonté qui (...) doit garantir par les seules présuppositions universelles de la communication, la justesse de tout accord normatif possible conclu dans ces conditions. (...) D'autre part, la discussion pratique se laisse concevoir comme un processus d'intercompréhension qui, d'après sa forme même, assigne à tous les participants en même temps l'adoption idéale de rôle. Il transforme donc cette adoption idéale de rôle effectuée par chacun en particulier et *privatim* en une opération publique pratique par tous intersubjectivement en commun. » (pages 18-19).

fumeurs par l'imposition de conséquences économiques, par exemple, une surtaxe pour les soins hospitaliers que leur habitude pourrait entraîner ?

On voit que la réflexion éthique nous mène à passer de l'étant, du domaine du fait, au domaine du devoir être, de ce qui serait souhaitable. Passage donc du fait constaté (la cigarette « cause » le cancer du poumon) à la norme (il est admis par le plus grand nombre que fumer est nocif), mais bien plus qu'à la norme aux valeurs (la santé est le plus grand bien) et finalement aux moyens de transmettre et surtout de faire appliquer cette valeur (il est interdit de fumer sous peine d'une amende). Or, à chacune de ces étapes, certains d'entre nous peuvent élever la voix et dire : attendez, je ne suis pas d'accord. Pas d'accord avec l'énoncé de fait : sur quelles bases, sur quelles études, repose ce «constat » demandera celui-ci. Pas d'accord avec la norme : quand bien même un sondage d'opinion démontrerait que le plus grand nombre croit que la cigarette cause le cancer du poumon, est-ce suffisant pour clore le débat ? Pas d'accord avec la valeur érigée : ce n'est pas la santé mais la liberté qui est le plus grand bien; à quoi sert d'être en santé sous un régime totalitaire ? Et finalement avec les moyens mis en œuvre : il est inadmissible de prohiber la cigarette sous prétexte qu'elle causerait des cancers car le moyen est disproportionné par rapport au fait.

Quiconque a un peu suivi les débats sur le cannabis aura fait le parallèle. Puisque le cannabis « cause » des torts à la santé (physique ou morale), la norme édicte que sa consommation est «dangereuse » et, au nom d'une valeur de santé publique (et de protection des plus faibles: enfants, adolescents etc.), il sera prohibé d'en produire, fabriquer, vendre, consommer, etc. C'est le fondement de la politique publique actuelle.

Comme nous le rappelle le professeur Malherbe, cette manière de poser le problème du cannabis – comme des autres substances d'ailleurs – nous invite à repenser la conception que l'on se fait de la santé, et par là de la médecine et de la science. Et plus loin encore, nous oblige à penser la question du risque et de la vie en société elle-même.

Nous vivons dans une société du risque, mais d'une manière paradoxale. D'un côté, nous valorisons la prise de risque : capital à risque, gestion du risque, ne s'imposer aucune limite pour réussir. On le voit aussi bien dans la valorisation de certains types de décision politique ou corporative, que dans l'émulation de certaines activités risquées, courses de formule 1, parapente, et autres sports extrêmes. De l'autre côté, nous devenons intolérants aux risques de la vie en société, aux risques que l'autre représente pour notre vie individuelle. C'est la quête de la sécurité, individuelle ou collective, contre le petit délinquant ou contre le terroriste. Le risque s'opposerait à la sécurité comme la maladie à la santé.

Or, entre ces deux attitudes apparemment opposées par rapport au risque, un subtil changement de référent se glisse qui explique pour partie le paradoxe. Dans la première acception (les risques que nous aimons prendre ou tolérons que les autres prennent) il s'agit bel et bien de risque. Ici, le risque est positif, il ouvre sur une augmentation du champ d'action: placé devant ce type de risque, l'acteur peut décider

de foncer, d'attendre, de renoncer. C'est, en tout cas, une expansion du champ des possibles, donc de l'autonomie, expansion qui n'est sans doute pas étrangère à l'admiration que ces personnes suscitent et qui est faite aussi d'un brin d'envie devant cette ouverture sur l'action que notre condition d'êtres «ordinaires » ne nous fournit que rarement. Le glissement de sens se produit avec la seconde acception qui ne renvoie pas à la notion de sécurité mais plutôt à la notion de danger. La sécurité est un bien collectif et individuel : pensons à la sécurité alimentaire, à la sécurité du travail. Par contre, le danger est, la plupart du temps, une privation, une limitation de la liberté d'action : devant le danger, la plupart d'entre nous nous arrêtons, nous retirons de l'action. En ce sens, le danger réduit la zone d'autonomie. Ce n'est donc pas la sécurité qui s'oppose au risque, mais le danger.[4] La distinction est fondamentale car elle renvoie au degré – réel ou perçu – de contrôle que chacun a sur son existence : nous sentons bien que le « *crazy canuck* » qui dévale les pentes est en contrôle – au moins relatif – des risques qu'il prend ; le danger a ceci de différent qu'il nous renvoie à la notion de perte de contrôle.

Nous en sommes, collectivement, à apprendre à gérer cette équation risque / danger. Le «risque » ici si l'on peut dire c'est de penser le risque comme une forme d'autonomie acquise pour soi, et le danger comme une limitation de cette autonomie par l'autre, entraînant dans son sillage les mouvements de repli sur soi, l'intolérance, bref la peur. Car si le risque peut être source de plaisir intense, le danger suscite généralement la peur. Et si le risque renvoie à l'amélioration d'outils qui me permettent d'être plus en contrôle de ma sécurité, le danger renvoie pour sa part au contrôle de ce qui est extérieur, au premier chef de l'autre.

Or, certaines conceptions de la médecine, de la science plus généralement, ajoutent au paradoxe lorsqu'elles parlent de facteurs de risque comme lorsqu'elles disent : fumer est un facteur de risque de cancer du poumon. De même en prévention de la délinquance : le décrochage scolaire est un facteur de risque de délinquance. Dans ces acceptions, le risque devient ici facteur de danger, le danger terminal étant bien sûr la mort (cancer). Cette conception mécaniste et causaliste de la prévention gomme la différence fondamentale entre le corps-machine que nous habitons et le corps-sujet que nous sommes, pour reprendre les distinctions que propose le professeur Malherbe. Il n'y a pas, en effet, une relation directe entre des caractéristiques «objectives » de notre environnement (incluant ici les caractéristiques personnelles de l'histoire génétique, familiale, culturelle, etc.) et la perception subjective que l'on a de soi et de sa relation avec son environnement. Pour le dire autrement, c'est exactement pourquoi deux enfants nés dans un environnement similaire, à la même époque, amis à la plus tendre enfance, prendront des chemins de vie tout à fait différents. Nous avons un bagage (le corps machine) ; ce que nous en faisons et comment nous interagissons avec ce bagage est une toute autre chose. Tout comme il n'y a pas de traduction immédiate du

---

[4] Le professeur Pires en fait une discussion intéressante : pages 41 passim.

fait à la norme, de même il n'y a pas de passage immédiat de mes déterminations biopsychologiques à mes actions et à mes réflexions.

Cette conception scientiste travaillant à l'identification de la « norme » statistique – les corrélations entre deux facteurs – perd de vue que nous ne sommes pas tous à la même position devant cette équation risque/danger. Ce qui, pour certains est un risque – descendre une montagne glacée sur un ski – est pour d'autres un danger réel.

> *« En dépit de tout ce que l'on croit savoir des toxicomanies, un nombre considérable de sujets bien informés « continuent de se suicider allègrement » au petit feu de leurs dépendances. Si l'éducation pour la santé est largement tenue en échec, et pas seulement dans le domaine des substances toxiques, ce ne peut être que parce que les sujets humains sont précisément des sujets, c'est-à-dire des être subjectifs dont les réactions de comportement sont liées bien davantage à la signification qu'ils attachent à leurs comportements qu'à l'objectivité des conséquences mécanico-médicales que l'analyse statistique prétend définir.*
> *Il y a des risques qui valent sans doute la peine d'être courus pour que la vie vaille la peine d'être vécue, qu'elle ne se dissolve pas dans l'enchaînement maniaque et peureux de précautions sans fin (…). Finalement, qu'est-ce qui est le plus humain (le plus autonome oserions-nous demander) : succomber à l'hypocondrie craintive et s'enfermer dans le cocon de la prévention universelle (au point d'y mourir aboulique ou asphyxié) ou bien vivre sa vie au travers des risques librement choisis et assumés ? »*[5]

D'où la position centrale du concept d'autonomie. Mais d'une autonomie conçue de manière critique comme *autonomie réciproque* et non comme d'une autonomie centrée sur l'individu isolé qui érige en norme son bon plaisir. Rappelons qu'autonomie signifie, étymologiquement, « se donner sa propre loi ». Il ne s'agit pas d'une loi arbitraire, faite pour soi seul, mais d'une loi qui impose de rendre possible, chaque fois où c'est possible, l'échange réussi avec l'autre, qui est le fondement même de la vie sociale. L'autonomie dont il est ici question repose donc sur la capacité de reconnaître la présence, la différence et l'équivalence de l'autre, permettant d'assumer respectivement la solitude, la finitude et l'incertitude, pour cultiver en retour la solidarité, la dignité et la liberté.[6]

La personne qui est « dépendante » n'est pas autonome dira-t-on. Et effectivement, dans cette sphère de leur vie, le toxicomane, l'alcoolique, le fumeur invétéré ne le sont pas. Pas davantage que la personne dépendante affective n'est pleinement autonome, ni celle qui aurait une addiction au jeu, à l'argent ou au sexe. La question suivante est de savoir jusqu'où, dans quelle mesure, l'État, la société, peuvent intervenir pour favoriser la lente conquête de cette autonomie. Et comment ? Quels sont alors les rôles de la gouvernance collective et du droit pénal comme outil de cette gouvernance ? Et comment la science pourrait contribuer à cet affranchissement ?

En tout cas, nous retenons, avec le professeur Malherbe que :

---

[5] Malherbe, J.F. (2002) *op. cit.*, page 7.

[6] Voir la discussion qu'en fait Malherbe aux pages 23-26.

« (…) le problème fondamental de notre civilisation n'est pas de savoir s'il est acceptable ou non d'interdire le commerce des dérivés du cannabis ou même leur consommation, mais bien de ne pas refouler l'expression de l'angoisse quand elle se fait jour, et mieux, d'inventer de nouvelles façons de l'apprivoiser. À cet égard, il n'est pas inutile de rappeler que toute contrainte injustifiée qui viendrait s'ajouter au fardeau déjà lourd de l'individu civilisé, ne peut que multiplier chez ce dernier le sentiment d'être l'objet d'un quelconque totalitarisme plutôt que le sujet de sa propre destinée. De ce point de vue, les campagnes antidrogue apparaissent décidément comme des tentatives de nier la mort plutôt que d'en reconnaître la présence dans la vie collective comme dans la vie individuelle. (…) Nous rejoignons ici N. Bensaïd qui aime à dire que la médecine préventive occulte notre peur de la mort en nous faisant mourir de peur. »[7]

De cette assise découle une définition de l'éthique comme « un travail auquel on peut consentir, qui s'effectue les uns avec les autres, pour réduire l'inévitable écart entre nos valeurs pratiquées et nos valeurs affichées autant que faire se peut. »[8] Travail avec, en effet, puisque cette autonomie ne peut s'exprimer sans un minimum de contraintes ; c'est le rôle de la gouvernance.

Nous retenons comme principe directeur qu'une politique publique éthique sur les drogues illicites, sur le cannabis en particulier, doit **favoriser l'autonomie réciproque construite à travers un échange dialogique constant au sein de la collectivité**.

LA GOUVERNANCE : MAXIMISER L'ACTION DES INDIVIDUS

Nous sommes des êtres sociaux. L'affirmation est triviale et cependant il est nécessaire de la rappeler puisque cela signifie que, *nécessairement*, nous nous trouvons toujours dans une situation paradoxale où chacun, doté (d'un certain degré) de libre-arbitre, prend des décisions librement pour lui-même et qu'en même temps, pour réguler les interactions avec les autres, nous établissons des règles, une normativité, plus ou moins complexe et plus ou moins formelle selon les cas. C'est vrai des relations de couple, des relations familiales, des joutes sportives, des relations de travail, comme des relations entre les citoyens et le gouvernement. La gouvernance de soi – acquise avec l'avènement de la démocratie libérale – n'est jamais entière et le cède inévitablement pour partie à la gouvernance par la collectivité.

La gouvernance est relativement facile à concevoir dans les relations simples : couple, famille, entreprise. Ce n'est pas dire que sa pratique soit simple : quiconque a une expérience de relations de couple saura dire à quel point il est parfois difficile de rendre explicites des règles implicites, et de s'entendre sur des règles de vie partagée. Néanmoins, la normativité qui s'établit entre amis, entre partenaires amoureux, entre parents et enfants, consiste en une série de règles relativement simples et surtout dont

---

[7] *Ibid.*, page 21.
[8] *Ibid.*, pages 27-28.

l'effectivité ne requiert pas, sauf lors de bris de relations ou d'abus, l'intervention d'autres parties.

Dans les sociétés féodales, pré-modernes ou pré-démocratiques, les règles prévalant aux relations sociales même simples étaient prescrites de l'extérieur : le souverain, le seigneur, le représentant de l'église, le père de famille ou l'ancêtre, le chef d'entreprise, chacun dans son domaine était tout puissant et pouvait ordonner et s'attendre à être obéi. L'établissement de la normativité se faisait largement sans l'implication des « sujets », sans leur consentement, sans qu'ils n'aient rien à dire ; ceux-ci étaient exclus du rapport de force. Au cours des siècles qui ont vu se construire les démocraties dans lesquelles nous vivons, nous sommes passés à des modes de gouvernement de soi et des autres permettant de plus en plus la participation des citoyens à l'élaboration des règles de la vie, aussi bien la vie personnelle que la vie sociale. Nous sommes aussi passés d'une situation où la vie de chacun était en quelque sorte réglée par son destin et fermée sur l'horizon étroit du lieu et des conditions de sa naissance, à une situation de vies «indéterminées », ouvertes sur la construction d'une identité et d'une destinée personnelle.

Changement donc dans les sources de normativité et leur opérationalisation dans la vie sociale, et changement aussi dans les rapports à la normativité. Dans le premier cas, on assiste peu à peu à la formalisation externe des sources de normes de comportement. Ne découlant plus du droit divin, celui du souverain ou celui du prélat de l'église, les normes sont construites à partir de la traduction politique de la volonté du peuple. Elles s'inscrivent dans des constitutions nationales, dans des décisions judiciaires (la *common law* britannique) ou dans des codes de loi (le Code civil). Il s'ensuit que les normativités supra-juridiques (héritées de droit divin) ou infra-juridiques (non dites par la loi) perdent et de leur valeur symbolique et de leur capacité effective à orienter les rapports sociaux, au profit de règles juridiques enregistrées selon une procédure admise et légitime dans le corps social par des textes de loi. Les sociétés modernes sont des sociétés de droit, c'est-à-dire des sociétés qui reposent sur la primauté de la loi dans la gestion des rapports entre les personnes et entre les personnes, les groupes et les institutions. Jamais entièrement incorporées par l'ordre juridique, les autres sources de normativité n'ont pas pour autant disparu ; elles sont moins visibles (les normativités pré ou infra juridiques), parfois moins légitimes.

Au changement de source, correspond un changement d'opérationalité : alors que le souverain ou le représentant de l'église pouvait condamner, voire exécuter, sans qu'il soit possible d'interroger la légitimité et la rationalité de leur décision – sauf à risquer une même condamnation – les moyens de rendre effective la volonté du peuple inscrite dans la légalité juridique passent aux mains de juges et du système judiciaire dans son ensemble. La normativité juridique est activée soit par l'autorité publique établie en droit (litiges d'ordre public et pénal par exemple), soit par les citoyens eux-mêmes (litiges d'ordre privé et civil) et rendue effective principalement par les tribunaux. Il existe des recours, et surtout ces recours sont théoriquement les mêmes pour tous et accessibles à tous.

Troisième modification, les relations qu'entretiennent les citoyens à la norme et, via la norme, à l'ensemble des aspects de la vie en société, changent aussi. La part du choix personnel et de l'incertain augmentent, jusqu'à mener, aujourd'hui, à un rapport non plus tant à l'autre qu'au risque que représente le fait d'être en contact avec l'autre. La normativité elle-même n'est plus acceptée comme une fatalité ni même comme une obligation. Sans qu'elle soit rejetée, la normativité sociale fait l'objet de questionnements sur la base d'expériences personnelles et d'une adaptation aux conditions individuelles d'existence. L'espace entre le sujet de la norme et la norme semble donc s'accroître en même temps que se formalisent les modes de résolution de conflits.

À travers la conjonction de ces processus, émerge une gouvernance de plus en plus instrumentalisée. Les instruments de la normativité, avocats, juges, tribunaux, acquièrent une importance parfois plus grande que les contenus eux-mêmes : la question immédiatement personnelle est de savoir si j'ai accès éventuellement aux mécanismes reconnus de résolutions de conflits, ou si j'en suis, par ma condition ou par mes actes, exclu d'une manière ou d'une autre. Pour le dire autrement, le moyen remplace la fin, la règle de droit remplaçant l'exigence de rapport à l'autre qui est au fondement de la normativité et de la vie sociale elle-même.

Les sociétés modernes sont donc confrontées à une série d'injonctions parfois paradoxales. La gouvernance collective doit : (1) permettre de réguler les rapports sociaux de la manière la plus ordonnée possible en même temps que la moins contraignante, (2) exprimer les normes et valeurs partagées par la collectivité en même temps que (3) laisser à chacun la possibilité de s'autodéfinir par rapport à ces normes et valeurs. Comment réconcilier ces oppositions du moins apparentes ?

À la suite des travaux du professeur Taylor[9], on peut soutenir qu'il y aurait deux sphères centrales ou deux objets privilégiés de gouvernance : la gouvernance des relations à autrui et la gouvernance des relations à soi. La gouvernance des relations collectives fait évidemment partie des sphères d'intervention traditionnellement reconnues à l'État, même si les formes et le contenu en changent. Par contre, la gouvernance de soi ne tombe pas immédiatement ni systématiquement sous la sphère de l'État.

La gouvernance de la collectivité

L'État n'est pas la seule source de normativité, loin de là. Le fait cependant que l'État démocratique doive agir selon la loi, et que la plupart de ses politiques publiques s'inscrivent sous la forme de textes de loi, mène à une sorte de court-circuit où la source du droit et l'État se confondent.

Pourtant, comme le rappelle à juste titre le professeur MacDonald, si le champ d'action de l'État doit effectivement s'exercer en respect de la règle de droit, le champ

[9] Notamment : Taylor, C., (1989) *Les sources du moi.* Montréal : Boréal.

du droit n'est pas limité à l'État. Dans toutes les sociétés connues, des règles ont toujours été établies pour gouverner le rapport à soi et aux autres. Elles sont implicites ou explicites, informelles ou formelles, d'application universelle ou restreinte, codifiées ou enregistrées dans la mémoire collective, extensives ou limitées à certains domaines d'action. Dans tous les cas, et quelles que soient la nature et la forme spécifique des règles, elles servent à exprimer les conditions du vivre ensemble parmi les membres de la communauté. Elles concernent le mariage et la parentalité, les manières de respecter la vie et le bien d'autrui, aussi bien que les rapports à l'invisible et à l'au-delà. Elles prennent la forme de prescriptions ou d'interdictions, sont mises en œuvre par l'évêque ou le mollah, par le souverain ou son représentant, ou par le juge. Contrairement à ce qu'on aurait tendance à penser, nous n'avons pas, modernes, inventé la codification des lois puisque le premier code juridique remonte à Hammourabi, roi de Babylone. En droit romain, Justinien a été le premier à proposer un code de lois. Et on pourrait encore citer les Tables de la Loi « remises » à Moïse.

En ce sens, nous rejoignons le professeur MacDonald sur le pluralisme juridique selon lequel il existe des sources multiples de normativité et donc de règles d'action que la loi formelle n'épuise pas. C'est la distinction entre la loi et la « juridicité ». Comme nous l'écrivions plus tôt, la juridicité prend sa source aussi bien dans la famille que dans l'entreprise, à l'école que dans le syndicat, dans le parti politique et dans la religion. Les « lois », ne sont qu'une manière de gouverner le rapport à l'autre selon un ensemble convenu de règles. En ce sens, la juridicité « c'est l'entreprise d'assujettir l'action à la gouvernance par des règles. »[10]

La juridicité coexiste bien entendu avec d'autres manières de gouverner l'action des individus et des collectivités : l'exercice du pouvoir brut et la guerre pour ne nommer que celles-là en sont d'autres formes. L'une des différences majeures cependant entre la juridicité et ces autres formes tient à la nature et à la source de sa légitimité. Instaurer des règles d'action de forme juridique implique une forme d'assentiment sinon de participation active à l'élaboration et à la mise en œuvre de la règle, qualités que la domination par un tyran ou par une armée d'occupation n'ont pas besoin et ne cherchent pas à s'approprier.

L'élaboration d'une juridicité formelle, prenant la forme de textes de loi adoptés par les assemblées législatives, et prescrivant des droits objectifs aussi bien que subjectifs est au cœur de la modernité. C'est d'ailleurs largement autour de ces questions que se pose celle plus spécifique du rôle de l'État : quand et dans quelle mesure élaborer des règles juridiques formelles sur ces deux objets, et comment les faire respecter ?

Les sociétés modernes ont donc ceci de particulier qu'elles ont, entre autres choses, consacré la primauté de la loi formelle sur les autres sources de juridicité pour la gouvernance des relations sociales, établi la nécessité que ces lois formelles soient adoptées et mises en œuvre par les systèmes législatif et exécutif de l'État, et instauré

---

[10] MacDonald, *op. cit.*, page 24 de la version anglaise.

des mécanismes d'arbitrage par un système judiciaire lui-même issue de l'État mais indépendant des deux premiers.

Ce formalisme de la loi, ou pour le dire plus précisément de la normativité à caractère juridique inscrit dans les textes de loi adoptés par l'État ne signifie nullement l'extinction des autres formes de normativité. Le professeur MacDonald en donne un exemple pertinent pour notre propos :

> [Traduction] *« Ainsi, des comportements que la loi pénale stigmatise et sanctionne seront au contraire, dans certaines communautés normatives, récompensés et encouragés. Dans des quartiers défavorisés où les opportunités économiques sont limitées, la production et la vente de drogues illicites peuvent être une manière d'échapper à la pauvreté. Pour ceux qui réussissent, l'amélioration du statut social est souvent plus attrayante que la menace des conséquences négatives de la sanction pénale. De même, au niveau international, dans les pays où la culture de plantes menant à la fabrication de drogues illicites est une activité indigène traditionnelle, et où la pauvreté est telle que les bénéfices économiques qui en découlent sont nécessaires à la subsistance, le droit pénal (qu'il soit national ou international) sera de peu d'effet.»* [11]

Autrement dit, la juridicité ne s'épuise pas dans la loi formelle, et le rôle de l'État dans la gouvernance collective ne se limite pas aux seuls processus d'adoption, exécution et arbitrage de lois formelles.

<u>*La gouvernance de soi*</u>

Historiquement, la juridicité a souvent été au plus près des normes morales, ou a cherché à s'y modeler. Ces normes morales pouvaient provenir de la religion, d'une philosophie, d'une éthique, voire d'une théorie de la nature universelle comme chez Platon. Dans tous les cas, elles cherchent à dire la vie bonne, que celle-ci consiste à se conformer aux règles immanentes de la vie, à mettre fin au cycle des réincarnations ou à éviter la damnation éternelle. Dans tous les cas aussi, la vie bonne correspondait largement à « la vie » en son sens le plus abstrait, c'est-à-dire qu'elle ne s'intéressait pas tellement au destin de chaque individu mais à la collectivité, au groupe, au clan.

Ce n'est qu'à partir de la seconde moitié du second millénaire, au cours de la période dite des Lumières, que la vie individuelle a commencé à s'inscrire peu à peu au cœur des préoccupations de la gouvernance de la collectivité. Ce changement majeur a fait en sorte que ce que Taylor appelle « la vie ordinaire », celle de « l'homme moyen sensuel », au cœur de laquelle se trouvent son rapport au monde et sa manière d'entrer en contact avec lui à travers les prismes privilégiés que sont la famille et le travail, a soudainement été reconnue. Auparavant généralement dépourvu de possibilités de participation à l'élaboration de la juridicité, le «citoyen » a alors acquis – on pourrait référer, pour simplifier, à l'exemple du droit de vote – un droit de regard et de

---

[11] *Ibid.*, page 25.

participation active non seulement comme membre de la collectivité mais comme individu unique et entier.

Les collectivités s'étaient jusqu'alors dotées d'une juridicité largement axée sur le rapport à l'autre, consacrant des droits objectifs forts – droit à la vie : tu ne tueras pas ; droit à la propriété : tu ne voleras pas ; etc., – et à composante cognitive faible : la démonstration du respect de la vie, même en admettant qu'elle a continué – et continue parfois malheureusement dans certains cas – à poser des difficultés même au cours du XXe siècle – pensons ici à l'inégalité raciale ou aux inégalités entre les genres – cette démonstration du respect universel de la vie n'est pas celle qui a le plus posé problème. C'est en ce sens que nous parlons ici, à la suite notamment du travail de Pires discuté à la section suivante, de normes à composante cognitive faible. Ce sont des règles fondamentales, dont certains philosophes du droit ont dit qu'il s'agissait de droits naturels, qui ne requièrent pas une justification empirique forte. Il n'en va pas de même pour d'autres types de normes concernant des conduites telles l'homosexualité, l'avortement… ou l'ingestion de drogues. Ces normes concernent plutôt ce qu'on pourrait appeler des droits subjectifs qui touchent davantage, on le voit par la liste des exemples donnés, des comportements individuels exprimant des choix personnels se réalisant à travers un échange consensuel, et concernent donc peu ou moins directement la collectivité. C'est pourquoi on pourra dire qu'il s'agit de normes à composante cognitive forte : pour s'imposer comme droits négatifs, c'est-à-dire comme contraintes ou prohibitions, ces normes ont besoin d'une justification exogène provenant de savoirs externes à la juridicité elle-même.

Ainsi, parallèlement au processus de formalisation juridique des normes de gouvernance de la collectivité décrit à la sous-section précédente, l'individu moderne a acquis un espace de plus en plus grand pour la gouvernance de soi. Cet espace de gouvernance de soi n'est plus, comme auparavant, dicté entièrement par les déterminismes subséquents à la naissance en tel lieu, dans telle famille, avec tel bagage génétique. Mais il ne s'agit pas non plus, sauf dans quelques situations totalitaires, d'un espace soumis tout entier aux préceptes de la collectivité ou de la religion. Cet espace est fait d'une vaste zone d'indétermination qui, pour partie, explique précisément ce qui est parfois nommé comme « désenchantement du monde », de manière plus prosaïque comme « perte de sens » ou « de valeurs ». En fait, nous dirions que ni l'un ni l'autre ne sont à l'œuvre autant qu'un processus lent et hésitant de recomposition du social dans et par de nouvelles manières d'être des individus en relation.

<u>Le rôle de la gouvernance</u>

La gouvernance s'inscrit donc à la fois sur le registre de la gouvernance collective par l'État et de la gouvernance de soi. Si le véhicule privilégié de l'État est la loi formelle, l'adoption de lois n'épuise pas tout le champ de la gouvernance collective. Par ailleurs, la gouvernance de soi consiste en la lente découverte – au sens fort du terme – de la juridicité qui sous-tend l'action humaine.

Le professeur MacDonald présente la question qui nous est adressée de belle manière :

> *« Comment le droit et les institutions juridiques peuvent-ils le mieux permettre d'atteindre la gouvernance symbolique de l'action humaine d'une manière qui facilite l'accomplissement juste des buts individuels et collectifs ?»* [12]

La question renvoie aux finalités de la gouvernance dans la collectivité : faciliter les rapports humains et la réalisation de soi, avec un minimum d'interférence de telle sorte à stimuler la découverte, en chacun de soi, de la source de la normativité plutôt que l'imposer de l'extérieur. Il n'est pas du ressort de la gouvernance par l'État d'assurer le bonheur ni la santé des citoyens. Il sera par contre de son devoir de s'assurer que les règles qu'il édicte et la manière de les concrétiser, nuiront le moins possible à la capacité de chacun de réaliser son être moral. Non plus donc une moralité unique, ou du moins une moralité pour tous, comme le soutenait la position dominante du rapport Le Dain, mais une facilitation de l'accès à la moralité pour les citoyens, moralité étant entendue ici au sens de cette découverte éthique des lois fondamentales dans le rapport à l'autre comme le soulignait le professeur Malherbe.

Le professeur MacDonald propose une définition de la gouvernance s'inspirant des travaux de la Commission de réforme du droit qui indique la voie : la gouvernance vise l'affranchissement et non le contrôle. De manière descriptive, il s'agit de définir les objectifs du vivre ensemble dans des politiques et des programmes d'action qui sont ensuite transmis par des systèmes et processus et soutenus par des acteurs permettant d'affirmer et de promouvoir l'action humaine. Véhicule privilégié de la gouvernance, la loi ne poursuit pas des finalités instrumentales de simple expressivité des règles ou prescriptions adoptées pour et au nom des citoyens mais est un processus de construction réciproque des relations sociales à travers lequel les uns et les autres, citoyens et gouvernements, procèdent à l'ajustement constant de leurs attentes de comportement.

Nous retenons donc comme principe directeur pour la gouvernance que **l'ensemble des dispositifs de l'État doit concourir à faciliter l'action humaine, et notamment les processus permettant de construire l'agencement entre le gouvernement collectif et le gouvernement de soi**.

LE DROIT PÉNAL OU LES LIMITES DE L'INTERDICTION

Nous aurons amplement l'occasion de décrire, au cours de ce rapport, à quel point le droit pénal est au cœur même de toute réflexion sur les drogues illicites. À tel

[12] MacDonald, *op. cit.*, page 78.

point que les débats autour de la législation criminelle, entre ce qu'il est convenu d'appeler les prohibitionnistes d'une part et les libéralistes d'autre part, en sont venus à primer outrageusement sur toutes sortes d'autres considérations. Le sociologue italien Pareto (1848-1923), cité par le professeur Pires dans son document de réflexion, disait des êtres humains que, même si nous aimons penser que nous sommes des êtres rationnels, nous sommes surtout des être raisonneurs, c'est-à-dire que nous voulons « donner une apparence de logique à des conduites qui n'en ont pas la substance ».[13] Dans le contexte des débats sur le cannabis, cette expression prend ici toute son ampleur : les deux camps en effet se renvoyant constamment leurs raisonnements comme autant de « vérités » avérées.

Une réflexion sur le rôle et la place du droit pénal en matière de drogues illicites, ici de cannabis, pose en effet la question des fondements de l'opportunité de recourir au droit pénal. Généralement, les deux camps s'empressent au plus vite de sortir de ce strict champ de réflexion sur les fondements pour recourir à la justification. Et d'un côté comme de l'autre, la justification n'a plus rien à voir avec l'outil lui-même, le droit pénal, mais avec l'objet visé, le cannabis. En découle alors la litanie des « preuves » sur les effets du cannabis. Pour les uns, ces effets sont suffisamment importants pour « justifier » le recours au droit pénal ; et de citer alors les risques associés à l'usage du cannabis : dépendance, difficultés d'apprentissage, délinquance, conduites avec facultés affaiblies. Pour les autres, ces mêmes risques sont tellement minimes, ou alors couverts par d'autres règles pénales (la conduite sous influence), qu'ils ne justifient pas l'intervention pénale. Quoiqu'il en soit, le débat n'est déjà plus sur les fondements mais sur la justification.

Cette réflexion sur le rôle du droit pénal consiste précisément à nous ramener sur le terrain des fondements. La question centrale sera de tenter d'identifier des critères qui aideront à décider dans quelles circonstances la société peut – ou doit – recourir au droit pénal. Il s'agira alors de décider si ces critères fondent ou non une intervention du droit pénal pour la gestion des enjeux posés par le cannabis.

Nécessité de la distinction

Soulever la question de savoir si l'intervention du droit pénal en matière de cannabis est fondée, renvoie nécessairement à une observation première : le droit pénal n'est pas fondé d'intervenir pour tous les comportements mais, dans certains cas, il l'est nécessairement. Cette observation s'appuie sur trois constats : (1) la plupart des rapports sociaux se régulent autrement que par le pénal ; (2) certains comportements font nécessairement partie du champ pénal ; et (3) certains comportements que le droit pénal, à certaines époques, criminalisait, ont été depuis exclus de son domaine . Cette possibilité d'inclure ou d'exclure des actions humaines du champ du pénal repose sur la capacité de faire des distinctions.

---

[13] Cité in Pires, A.P. (2002), *op. cit.*, page 8.

Mais une difficulté importante surgit dès qu'il s'agit d'admettre *dans les faits* – et non simplement en théorie – ce principe de la distinction. Une fois qu'un acte a été reconnu comme un « crime », il fait partie du fonds commun de ce qui définit tous les délits : des comportements contre la Société. Selon la logique interne du droit pénal la seule distinction admissible *précéderait* la décision d'incorporer ou non un comportement dans le droit pénal : s'il s'agit d'un comportement qui va contre le bien commun il s'agit d'un acte criminel, sinon, ce sera un acte incivil, peut-être même immoral, mais ce ne sera pas un acte criminel. Une fois cette décision prise, il n'y aurait plus que des distinctions de forme : type de procédure et sévérité des sanctions selon la nature du délit.

Tout se passe donc comme si, à l'intérieur du droit pénal, il n'y avait pas de distinction positive entre les délits, comme si la distinction ne se faisait qu'à l'extérieur, avant la constitution de l'acte en délit. Or, il existe des distinctions entre les types de délits. C'est la distinction que fait le professeur Pires entre les illicites standard et les illicites « à double face ». Il est plus courant de distinguer les crimes « sans victimes » des crimes « avec victimes », mais cette catégorisation est incorrecte. D'une part, pour le droit pénal, la victime c'est toute la Société. Il y a certes des victimes individuelles, mais en quelque sorte par extension, le tort étant en fait toujours celui infligé à l'ensemble de la société. C'est ce qui expliquerait par exemple le principe d'exemplarité, dans la théorie de la peine : en punissant un coupable on veut dissuader tous les autres qui pourraient être tentés d'agir de même.

D'autre part, cette catégorisation renvoie à un seul aspect, l'objet du délit, faisant perdre de vue les autres processus par lesquels le droit pénal distingue entre types de délits. Ainsi, un autre type de distinction intrinsèque au droit pénal relève du mode de justification. Décider de criminaliser l'homicide ne requiert pas, comme le souligne le professeur Pires, de mener des études comparatives pour décider si une forme de meurtre est moins nocive ou moins grave qu'une autre pour la victime. La composante cognitive est faible : ici, point besoin de recourir à des arguments externes pour justifier la pénalisation, l'acte en soi – c'est la notion de *malum in se* – suffit à établir la légitimité de la norme pénale. Rien de tel lorsqu'il est question des drogues : dès les débuts de la prohibition, il a été besoin de justifications externes relatives aux torts causés par l'usage de drogues et bien entendu à leur « démonstration », si faible fusse-t-elle. Ces objets de criminalisation ont une composante cognitive forte, en ceci donc qu'ils demandent une justification élevée.

La distinction entre les types d'illicites est donc un outil analytique nécessaire pour comprendre et réfléchir sur le rôle du droit pénal en matière de drogues. Ceci posé, quels sont les critères à partir desquels on peut exercer ces distinctions ? C'est l'objet de la sous-section suivante.

Critères de distinction

Le professeur Pires propose sept critères permettant de distinguer entre eux les divers types d'illicites en droit criminel.

Sept critères pour distinguer les délits	
Nature du délit	S'agit-il d'un conflit ou d'un échange ?
Discernement du droit	Le droit peut-il discerner une victime et la distinguer du déviant ?
Référentialité	L'auteur peut-il reconnaitre les conséquences de ses actes sur autrui ?
Limitation de la liberté	La limitation de la liberté de l'auteur à poser l'acte se pose-t-elle ?
Justification du délit	Le droit doit-il recourir à des savoirs externes pour justifier la norme édictée ?
Application du droit	L'application requiert-elle une intervention proactive ?
Effets de la loi	Les effets de l'application peuvent-ils remettre la norme en cause ?

Nous les examinons brièvement un à un.

La nature du délit

Pour qu'il y ait délit il doit y avoir un tort causé, ce qui renvoie à une victime. Nous le disions plus tôt, au sens le plus large, le droit pénal considère que la société est la victime ultime de tout délit. La victime directe d'une agression ou d'un vol, est un témoin au sens technique du droit. Mais à un niveau concret, le droit reconnaît des victimes directes. Dans certains cas, la notion de victime tombe quelque part entre les deux : c'est le voisinage, l'entourage, comme par exemple dans le cas des nuisances occasionnées par la sollicitation publique aux fins de prostitution. Mais ces situations de nuisances sont elles-mêmes à la limite du droit pénal, dans une sorte de zone grise entre les délits standard et les délits à double face.

Ce qui est remarquable c'est que le droit pénal ne peut observer les délits institués à partir des trois niveaux en même temps. S'il voit la victime directe, alors c'est la société qui devient invisible. Et s'il considère le voisinage, il est encore plus évident qu'il ne peut ni voir une victime directe ni non plus la société dans son ensemble. Enfin, et surtout, s'il regarde du point de vue de la société dans son ensemble, alors il perd de vue non seulement la victime directe mais de surcroît il perd du coup sa spécificité. En effet, dans ce dernier cas, il est permis de dire que le droit civil aussi protège la société : sans le respect des contrats de vente et des dettes, c'est toute la société qui fout le camp.

Ce ne sont donc pas uniquement le tort causé, ni même la présence d'une victime, qui confèrent à des actes leur caractère pénal mais le fait qu'ils témoignent d'un conflit, d'un abus de pouvoir, de l'empiètement d'un acteur social sur l'autre. Évidemment, le droit civil sert aussi à résoudre des conflits ; d'où la nécessité d'autres critères.

Le discernement du droit

Le droit est-il capable de discerner clairement une victime d'un auteur ? Dans le cas des délits standard c'est généralement le cas : la victime d'un homicide se distingue clairement de l'auteur. Évidemment, il se présente des exceptions à ces cas de figure purs, comme lorsque la victime est accusée par le droit pénal (le cas d'une femme victime d'agression condamnée pour outrage parce qu'elle refuse de témoigner contre son agresseur).

Dans le cas des délits à double face, le droit pénal peine à trouver la distinction entre la victime et l'auteur. Ou alors, il trouve en l'auteur la victime qu'il veut alors protéger contre elle-même, créant du coup la victime du fait de sa propre intervention.

Alternativement, et par voie de conséquence parce que conscient des limites et difficultés de punir la victime (par exemple la prostituée), le droit pénal décolle du monde phénoménal (la nature concrète des faits) et change de mode de raisonnement. D'un mode de raisonnement analytique (les raisons qui permettent de savoir) il passe à un raisonnement conséquentialiste ou téléologique (les buts pour faire). Par exemple, le droit pénal justifiera alors son intervention par la nécessité de protéger les enfants. Ce faisant, il perd – et nous fait perdre – de vue les raisons – au demeurant inexplicables – qui l'ont amené en premier lieu à se saisir du délit.

Référentialité

Nous entendons ici par ce terme la capacité pour l'auteur du délit à reconnaître, même avec des « explications », dénégations, et autres mécanismes de neutralisation, le tort causé à autrui par l'acte posé. Même dans certains cas limites des illicites standard tel que la cruauté à animal domestique, l'auteur du délit – par exemple il a pendu le chien du voisin à un arbre – pourra reconnaître que son geste a causé du tort au propriétaire de l'animal. Dans le cas des illicites à double face, le geste posé peut être autodestructeur mais il ne recèle pas de méchanceté à autrui, voire il ne met même pas en relation avec autrui. C'est d'ailleurs l'une des interrogations que nous pose le sociologue A. Ehrenberg sur les drogues en regard du déficit de rapport à l'autre dont témoignent toutes les formes d'usage de drogues lorsqu'interprétées comme repli sur soi. Mais nous ne sommes déjà plus dans la sphère du droit pénal mais dans celle de la réflexion politique sur la démocratie.

Limitation de la liberté

Nous en discuterons peu pour le moment puisque nous y reviendrons plus loin. Il suffira de dire que le droit institue de manière privilégiée des limites à la « liberté sauvage d'agir » comme le disait Kant : le droit pénal limite la liberté de prendre la vie ou la propriété de l'autre. Ce faisant il institue des droits-libertés c'est-à-dire le droit de jouir de sa vie et de sa propriété. La limitation par le droit des droits institués par lui, comme dans le cas de la prostitution où le droit intervient pour limiter le droit-liberté qu'il a institué de jouir de son propre corps et de sa liberté, lui pose donc des problèmes de fond.

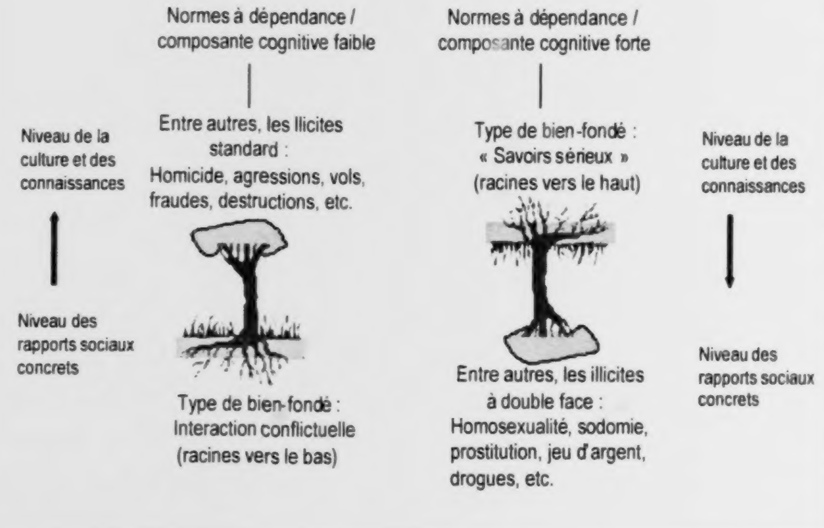
Justification du délit

Le droit pénal n'a pas, ou très peu, à recourir à des justifications externes pour justifier la criminalisation des délits. C'est l'exemple de l'homicide que nous donnions d'entrée de jeu : le droit pénal n'a pas recours aux disciplines de la sociologie, de l'anthropologie, de l'histoire, de l'économique ou de la médecine, pour connaître les effets différents de divers types d'homicides, de diverses manières de tuer. Tel serait aussi le cas des agressions sexuelles, du vol, de la fraude, etc. La composante cognitive de justification est faible. Le bien-fondé de l'illicite standard trouve son socle au cœur même des rapports sociaux :c'est parce qu'on sait qu'une société qui songerait même à permettre l'homicide serait une société invivable, ne serait plus une société, que nous ne songeons même pas à interroger le bien-fondé de l'interdiction pénale de l'homicide. La seule question qui se pose encore dans certains pays mais que le Canada a depuis longtemps déjà résolue est celle de la peine que la société se réserve le droit d'imposer pour le meurtre.

C'est le contraire pour les illicites à double face, qui requièrent une démonstration empirique, une justification à composante cognitive forte. Cette question, les lecteurs s'en doutent bien, est centrale à tout le débat sur les drogues. Ceux qui voudront bien d'ailleurs nous accompagner dans la lecture de ce rapport constateront l'importance que nous y avons nous-même accordée.

Nous reproduisons ci-dessous le très ingénieux graphique le professeur Pires.

Tableau 5 : Illustration de l'orientation renversée des fondements dans les illicites criminalisés



Comme le souligne le professeur Pires, le critère n'est pas ici de savoir s'il y a consensus ou *dissensus* sur la norme pénale, ces termes renvoyant à la manière et à la possibilité du débat démocratique. Le critère renvoie plutôt à la source de la légitimité de la norme : endogène ou exogène. Dans le cas des illicites standard, la source de légitimité est endogène. Dans le cas des illicites à double face, elle est exogène. Or, le processus de création de la loi pénale, lui, demeure le même : c'est le débat démocratique menant à l'adoption de la loi habilitante. C'est pourquoi il est facile de perdre de vue que les deux types de délits ne sont en fait pas de même nature.

> *« Le point important à retenir est que tous les illicites à double face auxquels ce critère s'applique présentent certains problèmes particuliers. (i) Ils ont un fondement endogène plus précaire, plus idéologique ou plus fragile parce qu'ils ne sont pas ancrés dans une déviance conflictuelle concrète et parce que les normes ne sont pas assez détachées de certaines formes de connaissance ou ne sont pas suffisamment indifférentes à la connaissance des faits. (ii) Ils sont alors plus sujets à un processus de sélection de la connaissance disponible et de la valeur affective de la connaissance que nous sélectionnons ou dont nous disposons à leur égard à un moment donné. Cela veut dire que l'examen critique et sérieux de la connaissance devient capital. (iii) Ils sont virtuellement plus polémiques et sujets à débat public à un moment donné et, aussi, susceptibles de se fonder sur des méprises culturelles ou cognitives majeures. »*[14]

Application du droit

Dans la très grande majorité des cas impliquant des illicites standards, les délits sont amenés à l'attention de la police par une plainte : vols, agressions sexuelles, homicides, font le plus souvent l'objet de plaintes à la police. En fait, environ 90 % de tous les délits connus de la police proviennent de plaintes. Dans le cas des illicites à double face, on avoisine les 100 % de délits recherchés de manière proactive.

On objectera qu'en matière de production de cannabis, il y a eu augmentation des plaintes de la part des voisins des plantations en Colombie-Britannique. Mais si les voisins se plaignent, ce peut être à cause des dangers réels d'incendie – puisque l'illégalité force les producteurs à détourner les lignes électriques – ou à cause de l'incitation au silence de quelque malfrat – toujours en raison de l'illégalité dans laquelle se trouve le producteur.

L'application proactive du droit pénal dans le cas des illicites à double face entraîne des effets pervers, tant en coûts sociaux et humains, qu'en possibilités d'application discriminatoire ou en corruption policière, dont il faut se demander toujours s'ils se justifient par les fondements endogènes du délit.

Effets de la loi

Découlant en quelque sorte du critère précédent mais aussi de tous les autres, celui-ci renvoie à la légitimité de la norme. Les difficultés et critiques que soulèvera la

---

14 Pires, A.P., (2002) *op. cit.*, page 59.

proactivité policière, les changements dans la normativité sociale ou dans les bases de connaissances, font en sorte que la loi devient contre-productive, suscitant *sui generis* l'interrogation de ses fondements et de sa légitimité.

Nous regroupons les critères proposés par le professeur Pires en trois couples, chacun ayant un côté «acte» et un côté «droit» à partir desquelles il est possible de saisir la distinction entre les délits de nature pénale.

Le premier couple concerne **la nature du délit**. Côté acte, la question porte sur la relation entre la «victime» et l'« auteur » : s'ils sont en situation de conflit ou en situation d'échange. Lorsqu'on renverse la pièce, la question est de savoir si le droit pénal peut ou non distinguer entre une victime et un auteur.

Le second concerne **la justification**. Côté acte il s'agit de savoir si l'auteur peut reconnaître ses torts à autrui. Côté droit, il s'agit de saisir l'origine de la légitimité de la norme.

Enfin, le troisième concerne **l'opérativité**. Côté acte, la question est de savoir si l'application de la norme instituée provient des victimes – ou témoins – ou si elle requiert une proactivité des agences d'application. Côté droit, il s'agit de savoir si la mise en application de la norme retourne ou risque de se retourner contre elle-même.

Selon nous, l'analyse des délits institués dans le Code criminel à partir de ces trois couples permet de répondre à l'interrogation fondamentale : la limitation de la liberté d'une personne à poser un acte se justifie-t-elle en droit pénal ? C'est pourquoi nous n'en faisons pas tant un critère que le résultat de l'application de ces critères à la norme instituée par le droit pénal.

Application aux drogues illicites

Les lois pénales sur les drogues illicites sont-elles un illicite à double face ? Sans doute.

Le délit créé implique un échange et il importe peu que l'objet de la transaction soit un objet prohibé ou non: l'échange entre les deux parties est un échange consentant. Lorsqu'il s'agit de l'usage de cannabis – ou à cet égard d'opium ou de coca qui par hasard pousseraient dans mon jardin – et que je décide de consommer, il n'y a même pas situation d'échange avec un autre. Pourtant, la possession au Canada, l'usage dans certains pays, sont prohibés.

Le droit pénal peine à trouver une victime. S'agissant de la conduite avec facultés affaiblies qui met en danger la vie d'autrui, il existe déjà une disposition du Code criminel punissant la conduite d'un véhicule sous l'influence de toute substance. Les difficultés d'application en matière de cannabis ne sont pas un argument. Elles se retrouvent tout aussi bien pour la conduite sous l'influence de médicaments d'ordonnance. Les enfants ? On voit mal comment le fait de consommer du cannabis nuit aux enfants, sauf si un marché sauvage, soit par absence de réglementation soit par la criminalisation actuelle qui alimente les marchés illégaux, cause du tort aux enfants.

En ce qui concerne la référentialité, l'auteur de consommation, et même le revendeur entre adultes consentants, ne se voient pas comme causant du tort à autrui. C'est vrai en tout cas pour les dérivés du cannabis. Évidemment, le coupage de l'herbe avec d'autres produits, le fait que des produits frelatés puissent être vendus, rappellent le temps de la prohibition de l'alcool – et c'est bien l'une des raisons pour lesquelles on a mis fin à ce système. D'autre part, pour justifier le délit, le droit pénal est obligé d'avoir recours aux savoirs externes sur lesquels il n'a pas de contrôle – ni non plus que sur leur interprétation – pour justifier la norme de comportement.

Enfin, l'opérativité de la norme suscite à la fois des problèmes d'application et une interrogation constante de la légitimité même de la norme.

En somme, les fondements de la norme pénale sont faibles lorsque la norme instituée (1) ne concerne pas une relation à autrui dont les caractéristiques sont telles que non seulement elle ne crée pas de victime mais qu'il n'y a pas d'auteur qui puisse se reconnaître comme tel ; (2) doit donc se justifier à l'extérieur des rapports sociaux fondamentaux dans la culture ; et (3) entraîne une application dont les effets pervers se retournent contre elle pour interroger sa légitimité. Lorsque le droit pénal intervient en ces matières, il fait de l'auteur la victime par le simple fait de la norme qu'il a instituée et qu'il tentera ensuite de sauver par la protection de l'auteur contre lui-même ce qu'il ne peut faire qu'au prix d'une fuite sans fin dans la production d'une connaissance qui lui échappe constamment.

Nous retenons de cette analyse que **le droit pénal ne doit intervenir que lorsque l'action visée implique un danger significatif et direct à autrui**.

LA SCIENCE OU LA CONNAISSANCE APPROCHÉE

« La population est généralement disposée à accepter que le choix des méthodes de contrôle soit déterminé par l'interaction entre des spécialistes du secteur de la santé et des organismes gouvernementaux, car on reconnait que le médicament est utilisé essentiellement pour assurer son bien-être et on se fie aux spécialistes en la matière pour décider de la meilleure façon de protéger la population.

(...)

C'est donc dire que pour formuler une politique sociale sur leur usage non médical, vous devez tenir compte non seulement des préjudices causés par la loi ou par la drogue, mais autant que possible de l'analyse intégrale des avantages et des coûts de la consommation de drogues et des mesures antidrogues et de toute modification à ces mesures que vous pourrez envisager. C'est à la société tout entière de décider, et non aux experts en fonction des connaissances scientifiques. » [15]

---

[15] Dr. Harold Kalant, professeur à l'Université de Toronto, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, fascicule no 4, pages 69 et 78.

Depuis le tout début de nos travaux, nous étions conscients que la connaissance, même à prétention scientifique, ne suffirait pas à élaborer une politique publique sur les drogues illicites, sur le cannabis en particulier. On pourrait penser qu'un Comité spécial d'étude sur les drogues illicites, le cannabis dans ce cas-ci, ne devrait fonder ses conclusions et recommandations que sur le savoir. Pourtant, nul savoir ne peut jamais à lui seul définir une politique publique. À cela, nous invoquons plusieurs raisons.

(1) Premièrement, le savoir, ou plus correctement les savoirs, sont condamnés à être une œuvre ouverte, jamais définitive. Le processus de connaissance est par définition une interrogation constante sur le champ de l'inconnu, l'humble reconnaissance de l'immensité de la tâche en même temps que de son caractère approximatif – un bricolage aurait dit l'anthropologue français Claude Lévi-Strauss – ainsi que la reconnaissance de la complexité. Reconnaissance encore de l'ignorance où nous demeurons devant les questions fondamentales, questions toujours ouvertes par définition. Citons le professeur de Koninck :

> *« Il convient, en un mot, rappelions-nous, de célébrer l'ignorance où nous voilà enfin parvenus – car elle fait partie maintenant de l'ignorance connue (la simple ignorance dans le vocabulaire classique), par opposition à l'ignorance ignorée (la double ignorance – grâce aux neurosciences, à l'océanographie, à l'astrophysique, mais aussi grâce à la psychologie des profondeurs, à l'histoire des religions (pour ne citer que deux des « sciences humaines » avancées) et à tant d'autres disciplines qui ont spécialement progressé à notre époque. La célébrer par l'émerveillement et la perplexité qui sont toujours le sine qua non de toute découverte. »* [16]

Situation en apparence paradoxale puisque jamais tant d'informations n'ont été produites – dans tous les domaines de la culture humaine mais aussi spécifiquement en matière de drogues – qu'à l'époque contemporaine. À telle enseigne d'ailleurs que les spécialistes de toute sphère – économistes, sociologues, criminologues, psychologues, et autres généticiens – sont devenus les personnages incontournables du grand jeu de la justification des décisions des politiques publiques. Si on agit sur la qualité de l'environnement, si par exemple on reconnaît la réalité des phénomènes de réchauffement climatique et d'effet de serre, ce sera parce qu'une commission scientifique en aura persuadé les décideurs. Si on prend telle décision macroéconomique, elle sera expliquée au bulletin de nouvelles par un économiste patenté. Et que se produisent des violences urbaines ou l'hécatombe d'un tueur en série, on entendra psychologues et criminologues expliquer l'événement, voire justifier une orientation de politique pénale. Production massive d'information et circulation des experts dans l'arène politique habillent alors les processus de décision publique d'un manteau de crédibilité, sinon de légitimité. Le citoyen, désemparé voire désabusé par ce qu'il perçoit d'écart entre le monde vécu et le monde représenté dans les moyens de distribution – toujours inégale – de la culture, se sentira d'autant moins autorisé à

[16] De Koninck, T., (2002) *op. cit.*, page 25.

questionner la décision politique qu'elle sera justement investie du pouvoir de la « connaissance ». L'information devient connaissance, le savant un expert, et le politique, de moins en moins capable de réflexion sur des principes et des fondements, et surtout de réflexion autonome, se satisfait de cette armée commode «d'experts » toujours disposés à se faire conseillers.

Mais l'information n'est pas la connaissance. Et la connaissance ne se réduit pas à de l'information. La toile Internet déborde certes d'informations, mais personne n'osera dire que tout ce qui y circule mérite le qualificatif de connaissance.

(2) Deuxièmement, la production de la connaissance est fragmentée, à l'image de la vie moderne elle-même, refusant de poser la question du sens. L'assemblage bout à bout des disciplines universitaires n'est pas plus à même de produire de la connaissance, chacune posant ses questions à partir de son propre domaine d'expertise, ne regardant qu'à partir de sa lorgnette, qu'une seule de ces disciplines isolément. Les appels à l'interdisciplinarité et à la transdisciplinarité sonnent aussi creux que les incantations au « partenariat » dans le champ du social, alors que demeure absente une véritable volonté de compréhension, une tentative au moins de reconstitution du sens. Tout se passe comme si, dans le champ des drogues, un institut aussi prestigieux que le NIDA, gérant des budgets de recherche proprement astronomiques, menant des études qui, en soi, peuvent être fascinantes voire utiles, tout se passe comme si donc, cet institut n'avait pour objectif que de démonter, pièce après pièce, les mécanismes bio-psychologiques de la « toxicomanie », pour démontrer que l'usage de ce que l'institut appelle des drogues d'abus mène à des abus qui sont dangereux.

Or, le sens d'une pratique ne se réduit pas à sa décomposition en diverses parties, ni non plus qu'en un ramassis de ses recompositions. La connaissance remarquable des mécanismes cellulaires et de la génétique ne nous donne pas à la biologie plus de réponses aux questions éthiques et politiques que pose le clonage. Pas plus que la connaissance des mécanismes de l'atome et de la fission nucléaire n'avait fourni de réponses à la fabrication et à l'utilisation des armes nucléaires. Et la « science » économique, hautement abstraite et imprégnée de mathématiques, est à ce point détachée de la réalité qu'elle n'est plus capable d'expliquer le clivage entre les nations ni celui entre richesse extravagante d'un côté et misère humaine de l'autre.

Férus de jeux mathématiques et d'abstractions, les chercheurs semblent de moins en moins capables de poser les questions fondamentales. Leurs champs de connaissance sont parcellaires, découpés en autant de seigneuries que l'étaient les terres à l'époque de la colonisation, et tout autant ils peuvent donner l'impression du progrès du savoir, tout autant ils confondent connaissance et technique, savoir et expertise. Reposer les questions fondamentales, c'est être capable de faire des liens entre les domaines, c'est restaurer la complexité au nom de la nécessaire production du sens. On est loin d'ailleurs d'avoir résolu les débats entre scientifiques et philosophes sur

l'unification possible du discours et les débats sur la voie d'une connaissance intégrée de l'humain demeurent ouverts.[17]

(3) Se pose ensuite le problème des « experts », ces « idiots savants ».

« Idiots *est le mot juste (du latin* idiota, *«ignorant», emprunté au grec* idiôtês, *«ignorant», par opposition à* pepaideumenos, *«homme cultivé»). Le malheur est que leur réputation imméritée d'experts étend d'autant plus l'influence de cette idiotie en des sociétés comme les nôtres où la «science» exerce un pouvoir magique et où «le pouvoir semble de plus en plus légitimé par des experts «savants»», comme le relève Jacques Testart : «En effet, l'expert rassure et les citoyens hésitent à affirmer l'absurdité ou le cynisme d'une décision politique ayant reçu l'aval des «experts les plus qualifiés».* »[18]

Il ne s'agit pas d'accuser la science mais de récuser la difficulté de penser. C'est une chose de mener des études pointues, sur des questions précises, c'est une autre chose de prétendre «expliquer », à partir de ce savoir fragmentaire, et encore plus de fournir des réponses que, de toutes façons, la science ne peut fournir. On peut, en effet, mener des études sur le comportement des rats de laboratoire suite à l'injection d'une dose de Δ9-THC (le principal composant actif du cannabis), c'est autre chose de prétendre que ce type d'expérimentation révèle quoi que ce soit d'utile pour comprendre l'usage de cannabis et ses effets chez les humains. Moins encore pour fournir une réponse aux questions de politique publique sur le cannabis.

Geste social, comportement inscrit dans une histoire, l'usage de drogues ne se réduit pas à des mécanismes neuropsychologiques. Il peut être utile de connaître les mécanismes en jeu ; cette connaissance ne sera par contre pas suffisante pour expliquer le sens de l'expérience de la drogue dans nos sociétés.

(4) À la colonisation de l'esprit par le pouvoir de l'expert – qui se place en médiateur entre le politique et la collectivité – correspond une dangereuse colonisation de la réflexion des sciences de l'humain par l'attrait qu'exercent les sciences naturelles. Il n'y a là rien de neuf, ce mouvement avait commencé en fait dès le XIXe siècle, mais il s'est gravement amplifié au cours du XXe et notamment par le rapprochement toujours plus étroit entre la psychologie et les neurosciences. Il en résulte une transposition des méthodes et des manières de poser les problèmes par laquelle les sciences de l'humain s'imposent un réductionnisme (isoler des facteurs de leur contexte) quantitativiste (mettant l'accent sur la mesure mathématique). D'où une crise de connaissance. Quand on prendra un échantillon de 100 jeunes choisis aléatoirement dans la population, et qu'on les exposera à une batterie de tests psychologiques pour savoir

---

[17] Nous renvoyons là-dessus au très beau dialogue entre un philosophe et un neurobiologiste : Changeux, J.P. et P. Ricoeur (1998) *Ce qui nous fait penser. La nature et la règle.* Paris : Odile Jacob, entre autres les pages 77-78

[18] De Koninck, T. (2002) *op. cit.*, page 6.

pourquoi ils consomment du cannabis, on aura de l'anecdote à saveur sérieuse et une série de corrélations peu susceptibles de nous révéler les sens de l'usage de drogue.

Il fait bon ton dans certains milieux académiques et centres de décision de parler de politiques qui soient « *evidence-based* ». On entend par là des politiques basées sur la preuve « scientifique » de ce qui marche. L'un des exemples les plus puissants était la Stratégie de réduction de la criminalité adoptée en 1998 par le gouvernement travailliste nouvellement élu en Angleterre. Avec des sommes considérables destinées à soutenir des projets de prévention dont des études avaient démontré l'efficacité, cette stratégie devait réduire divers types de crimes de tant de point de pourcentage sur cinq ans.[19] Nous sommes en 2002 et l'Angleterre traverse présentement une « crise » sur l'insécurité publique en partie parce que les niveaux de criminalité ont en fait augmenté, et la stratégie de réduction de la criminalité est en plein désarroi.

Il serait tentant de se demander : mais comment pouvait-il en être autrement ? Les stratégies d'ingénierie sociale datent du XIXe siècle, et ont rarement donné des résultats concrets, qu'il s'agisse du contrôle des populations ou de la criminalité. Fondées sur quelques « recettes » elles-mêmes tirées de quelques expérimentations contrôlées, elles « oublient » la complexité du monde contemporain plus que jamais fait d'interdépendances et de foyers multiples de relations, plus que jamais fluide et insaisissable, et qui n'a de cesse de nous renvoyer à la complexité. Est-ce pour la fuir qu'on se réfugie alors dans l'abstraction mathématique des corrélations entre variables prétendument prédictives ?

Nos travaux ont fait la part belle aux connaissances issues de la recherche ; la seconde partie de notre rapport en témoigne abondamment. Nous avons tenté, ce faisant, de faire justice à la connaissance élaborée au cours des dernières décennies. Nous ne voulions, ni d'ailleurs ne pouvions en faire l'économie. Nous recommanderons aussi que se poursuive l'effort de connaissance sur certaines questions que nous avons jugées importantes.

Pour autant, nous n'avons pas la prétention d'avoir répondu à la question fondamentale, pourquoi les gens consomment-ils des substances psychoactives, alcool, drogues ou médicaments. Nous avons d'ailleurs été étonnés, considérant la quantité d'études menées chaque année sur les drogues, de constater qu'il s'agit d'un domaine où la recherche fait défaut. Comme si la recherche de réponses à des questions techniques avait fait perdre de vue cette question au fond si basique !

La connaissance scientifique ne remplace ni la réflexion ni non plus que la décision politique. Elle est une aide à la décision. Et c'est de cette manière que nous la pensons la plus à même de contribuer à la politique publique sur les drogues. C'est en tout cas notre principe directeur : **la connaissance scientifique, qui doit continuer d'explorer des questions pointues sur des enjeux clés, tout en poursuivant la nécessaire réflexion sur les questions globales, est une aide à la décision de politique publique**. Ni plus, mais ni moins.

---

[19] Le chapitre 20 en parle plus en détail puisque cette stratégie incluait un volet drogue.

CONCLUSIONS

L'un des grands défis que nous posent les sociétés modernes est d'inventer ensemble des lieux et des modes de socialité au delà des anciens réflexes de gestion de l'espace public par la volonté législative exprimée par la loi formelle. Devenus sujets de droits, objectifs et subjectifs, les citoyens participent de plein droit à la définition, nous dirions même à la conquête, du projet collectif du vivre ensemble. Il ne suffit donc plus d'édicter des lois qui, parce qu'édictées par le Parlement suivant les règles, devraient recevoir l'assentiment immédiat. Il faut concevoir des formes de participation éthique, par des échanges communicationnels, aux modes de définition du gouvernement collectif et du gouvernement de soi. Qu'on soit ou non d'accord avec les modes d'expression qu'ils prennent ou même avec le contenu, c'est bien ce que demandent les mouvements de la société civile qui s'opposent à la mondialisation décidée en conclave ou qui appellent à privilégier un développement durable et équitable : comment définir, ensemble, une normativité partagée où le gouvernement collectif et le gouvernement de soi peuvent se nourrir, se faciliter, mutuellement.

Nous retenons de cette excursion en terrain réflexif **qu'une politique publique sur les drogues illicites, sur le cannabis dans le cas qui nous occupe, repose sur une éthique de l'autonomie réciproque, soutenue par une volonté de favoriser l'action humaine, ne faisant intervenir le droit pénal que lorsque l'action visée implique un danger significatif et direct à autrui, et invitant l'élaboration de connaissances susceptibles de guider et de favoriser la réflexion et l'action.**

CHAPITRE 4

UN CONTEXTE EN MOUVANCE

Nos travaux s'inscrivent dans l'histoire, dans *une* période historique donnée. Cette histoire n'est pas simplement un champ externe à nous, quelque chose qui serait là, dehors, et n'aurait pas d'influence sur ce que nous faisons. Elle est étroitement entremêlée avec nos actions, les influençant de diverses manières subtiles. En même temps, parce que nous sommes en train de vivre cette histoire et de la faire, nous n'avons pas la distance nécessaire pour en reconnaître tous les éléments, ni non plus pour en comprendre toutes les implications. Néanmoins, pour resituer nos travaux dans leur complexité et dans l'incertain, nous avons la responsabilité de tenter de cerner certains éléments de cette histoire en-train-de-se-faire. Ce court chapitre tente d'identifier certains éléments qui nous paraissent pertinents. Nous en identifions six que nous distinguons sur deux plans, reconnaissant que ces niveaux sont en interaction nécessaire. Au plan international, la globalisation des marchés et les mouvements d'intégration économique, voire politique ; la montée en puissance du discours sécuritaire et l'équation drogues = criminalité ; et les éléments de changement qui se dessinent dans certains pays en matière de politiques sur les drogues. Au plan national : l'activisme judiciaire qui se traduit en décisions significatives au moins sur le registre de l'usage thérapeutique du cannabis ; l'adoption de la Stratégie nationale sur la sécurité des collectivités et la prévention du crime ; et la lutte au crime organisé.

MUTATIONS DU CONTEXTE INTERNATIONAL

Les deux dernières décennies ont vu se produire des mutations importantes tant dans l'ordre international que dans la structure des États nationaux. Il ne s'agit pas d'en faire l'historique ni même une analyse ; nous n'avons pas cette prétention. Cependant, quelques-unes de ces mutations ont une incidence certaine sur les drogues.

Globalisation et intégration

Depuis le début des années 1980, avec la déréglementation des marchés, on assiste à une globalisation des échanges économiques et à une intégration continentale

plus importante. La fin de la guerre froide et la disparition du bloc soviétique, de même que l'ouverture de la Chine aux marchés capitalistes, n'ont fait qu'accroître le rythme de ces mouvements. On en a vu pour résultat notamment la plus grande intégration de l'espace économique européen consacrée dans les accords de Maastricht ainsi que dans l'Accord de libre échange nord-américain entre le Canada, les États-Unis et le Mexique.

Au même moment, les changements technologiques rapides, notamment par l'Internet et la communication par satellite, ont contribué à ouvrir encore davantage, quoique de manière et à des rythmes différents selon le niveau de développement des pays, les frontières de la circulation des biens, des services et des capitaux. De même, l'accroissement des flux de populations et des voyages a mené, parfois par défaut voire contre la volonté de certains États, à une plus libre circulation des personnes.

Ces mutations ont eu des impacts importants sur les marchés des drogues illicites. L'ouverture des marchés et des frontières a bien sûr créé de nouvelles opportunités pour le blanchiment d'argent, tout en augmentant les difficultés de contrôles aux frontières et dans les transports. On oublie trop souvent cependant certains effets des politiques macroéconomiques régissant les flux mondiaux des capitaux et des ajustements structurels qui sont attendus, notamment des pays en développement. Une étude produite pour le Programme des Nations Unies sur le contrôle des drogues le démontre bien.

> [Traduction] *« Les efforts pour atteindre la stabilité (de la balance des paiements) visent souvent à réduire le déficit extérieur en réduisant les niveaux de consommation intérieure. Les politiques de stabilisation macroéconomique obligent souvent les gouvernements et / ou le secteur privé à diminuer leurs dépenses.*
>
> *Lorsque la croissance monétaire diminue, une infusion de monnaie forte peut gonfler la réserve monétaire d'un pays, réduisant ainsi les difficultés associées aux politiques fiscales et le niveau d'endettement. L'argent de la drogue peut alors devenir un outil de stabilisation, une source de capital sans conditions attachées. Les pays qui servent de réservoirs aux revenus tirés du trafic international de drogues peuvent donc en retirer des bénéfices importants. »* [1]

De plus, la tendance à la privatisation de secteurs entiers de l'économie nationale, notamment dans les pays d'Europe de l'Est après la chute du Mur de Berlin, mais aussi dans plusieurs pays d'Amérique latine et d'Asie, dans un environnement où les mesures de régulation interne et la disponibilité du crédit sont faibles, favorise les capitaux du crime organisé, notamment en provenance du blanchiment de l'argent de la drogue. On constate d'ailleurs que la concentration de la production industrielle dans ces pays n'a pas nécessairement diminué après la privatisation, favorisant en retour la pénétration du crime organisé.[2]

---

[1] Keh, D.I. (1996) *Drug Money in a Changing World. Economic Reform and Criminal Finance.* Vienna : UNDCP, technical paper no 4.
[2] *Ibid.*, pages 11-13.

On oublie aussi trop souvent le rôle des investisseurs des pays développés d'où proviennent les poussées à la déréglementation et à la libéralisation des marchés. Dans ces pays, comme le note Campodònico « *(r)ares sont les poursuites contre les grands trafiquants de drogues ou les institutions financières du monde industrialisé, là où pourtant la plupart des bénéfices du trafic de drogues sont engrangés.* »[3] Il en résulte un double discours, où les nécessités de la libéralisation des capitaux pour les multinationales rendent impossible de distinguer entre les capitaux propres et les sales. Le cas de figure du Pérou que développe Campodònico comme celui de la Russie qu'examine Keh, offrent des ressemblances structurelles frappantes.

La fin de la guerre froide a aussi signifié que les pays alliés au bloc soviétique, ou les groupes internes de guérillas, ont dû se tourner vers d'autres sources de financement. C'est l'analyse de l'Observatoire géopolitique des drogues et de son fondateur Alain Labrousse, qui comparaissait devant le Comité le 28 mai 2001, mentionnant à titre d'exemple le cas du Kosovo :

> *« À cet égard l'affaire du Kosovo est exemplaire. La création de l'UCK a été financée par un intense trafic d'héroïne provenant d'Istanbul et vendant l'héroïne en Suisse pour acheter des kalachnikov et des armes de poing, qui ensuite étaient en vente pratiquement libre et étaient stockées dans la région albanaise de Macédoine. »*[4]

Et comme pour faire le lien avec les effets pervers de la libéralisation et la mise en cause de la macroéconomique, M. Labrousse écrivait dans un livre précédent

> *« Selon les estimations, le trafic des drogues dans le monde génère entre 420 et 577 milliards de francs de chiffre d'affaires annuel. Le rôle grandissant que jouent ces fonds dans les processus de démocratisation et de restructuration économique conduit à une explosion des cultures et des trafics en Asie, en Afrique et à l'Est. C'est cette manne, dans laquelle puisent les pouvoirs locaux de toutes sortes, qui alimente les conflits nationalistes, ethniques ou religieux du tiers monde et des pays de l'ancien bloc communiste. Les drogues, enjeu économique, outil de pouvoir, sont dorénavant une donnée des relations internationales. Au-delà de quelques gros trafiquants, les systèmes bancaires des pays riches, le FMI, les grands organismes internationaux sont mis en cause. »*[5]

Rejoignant d'autres analystes, M Labrousse observe que les pays développés ne sont pas à l'abri des critiques puisqu'ils «ferment les yeux » lorsque leurs intérêts, notamment stratégiques et économiques sont en cause.

---

[3] Campodònico, H. (1996) «Drug trafficking, laundering and neo-liberal economics : Perverse effects for a developing country. » in Dorn, N. et.alii (eds) *European Drug Policies and Enforcement*. London : Macmillan Press, page 231.

[4] Sénat du Canada (2001) Délibérations du Comité spécial sur les drogues illicites, Ottawa : Sénat du Canada, première session de la trente-septième législature, fascicule 3, page 27. On consultera aussi en ligne les rapports de l'OGD à l'adresse : www.ogd.fr

[5] Labrousse, A. et A. Wallon (1993) *La Planète des drogues : organisations criminelles, guerres et blanchiment*. Paris : Seuil.

> *« Un incident s'est produit et a été reproduit par la presse quand le groupe d'action financière internationale a dressé la liste des pays suspects de se livrer au blanchiment d'argent, on n'a trouvé ni l'île anglo-normande de Jersey ni la principauté de Monaco, ce qui a étonné tout le monde. On a appris par la suite qu'il y a eu une négociation entre la France et l'Angleterre pour que chacun évite de mettre son pays sur la liste relativement infamante. »*[6]

C'est aussi le cas des intérêts européens au Maroc et en Afrique plus généralement, ainsi qu'américains, envers les paradis fiscaux.

De son côté, le rapport 2001 de l'Organe international de contrôle des stupéfiants (OICS), organisme des Nations Unies chargé de surveiller l'application des traités internationaux relatifs au contrôle des drogues consacre son premier chapitre aux effets de la mondialisation et des nouvelles technologies. Il observe qu'à côté de leurs « innombrables avantages » la mondialisation et les nouvelles technologies ont entraîné des effets pervers : atteintes aux identités culturelles, atomisation politique et sociale, marginalisation et pauvreté grandissante dans certains secteurs. Selon l'Organe, *« les revendeurs et trafiquants de drogues exploitent ces disparités pour tenter de développer de nouveaux marchés. En outre, au cours des 10 dernières années, l'expansion de l'activité commerciale et financière a permis aux délinquants de mieux dissimuler les transferts illicites de marchandises comme les drogues et les précurseurs placés sous contrôle international, et les profits qu'ils en tirent. »*[7] Selon le rapport, les nouvelles technologies sont utilisées par les trafiquants de drogues de deux façons différentes : pour améliorer l'efficacité de la livraison et de la distribution des produits, pour se protéger et protéger leurs activités illicites, pour commettre des délits classiques selon de nouvelles méthodes ou commettre de nouveaux types de délits.[8] Le rapport note entre autres ce qui suit :

- La Commission interaméricaine de contrôle de l'abus des drogues notait pour 1999-2000 qu'Internet était devenu le moyen le plus utilisé pour développer la production de drogues synthétiques dans certains pays de la région ;
- L'organisation internationale de police criminelle (Interpol) notait en 2000 que plus de 1 000 sites Web proposaient la vente de drogues illicites, principalement du cannabis ;
- Le recours accru aux virements électroniques ainsi que l'augmentation considérable du volume et de la rapidité des flux monétaires réduisent la possibilité de détecter les mouvements de capitaux illicites ; et
- Le Groupe d'action financière sur le blanchiment de capitaux (GAFI) a attiré l'attention sur le fait qu'Internet pouvait aggraver certains risques

---

[6] Labrousse, A., *op. cit.*, pages 28-29.
[7] Organe international de contrôle des stupéfiants, *Rapport pour 2001*. Vienne : Organisation des Nations Unies, page 1.
[8] *Ibid.*, page 2.

classiques de blanchiment d'argent : facilité d'accès, dépersonnalisation des contacts, et rapidité des transactions.[9]

Bref, si la recherche d'une plus grande cohérence, voire d'une meilleure prévisibilité des marchés internationaux, porte de grandes promesses, notamment pour les pays en développement, elle comporte aussi, indépendamment de toutes autres considérations de géopolitique, des effets pervers. De surcroît, ces qualités ne sont pas sans présenter des avantages aussi… pour les groupes de criminalité organisée.

Errances d'un discours sécuritaire

Au cours de cette même période, on a vu s'installer peu à peu, dans divers pays du monde occidental, un discours sur la sécurité intérieure en réponse à la hausse perçue ou réelle de la criminalité et du sentiment d'insécurité des populations. On a pu en voir des effets aussi bien dans des campagnes électorales axées sur la loi et l'ordre que dans une dérive vers des mesures jugées répressives par d'aucuns, telles les politiques de tolérance zéro.[10]

En matière de drogues, ce discours se décline sous deux volets principaux. D'abord, à compter du début des années 1980 sous la présidence de Ronald Reagan aux États-Unis, un discours de «guerre à la drogue » qui dépassera largement les frontières américaines. Ensuite, à compter de la fin des années 1980, une équivalence de plus en plus forte entre drogues et criminalité.

Le discours de la guerre à la drogue a permis de consacrer des ressources sans précédent à la lutte antidrogues. Souvenons-nous que c'est à cette époque que le Canada a lancé la première phase de sa stratégie antidrogues avec un budget de 210 millions $ sur cinq ans. Aux États-Unis, la « guerre à la drogue » a signifié concrètement la multiplication par 17 des dépenses fédérales consacrées à la lutte antidrogues : elles sont passées de 100 millions $ au début des années 1970 à plus de 18 milliards $ pour le seul gouvernement fédéral en 2002. Les dépenses combinées du fédéral et des États pour la guerre à la drogue sont estimées à plus de 40 milliards $ en 2000.[11] De même, cette guerre a signifié le quadruplement de la population carcérale américaine, passant de 500 000 détenus au début des années 80 à plus de 2 millions à la fin des années 90.

> [Traduction] *« Au cours des années 1990, les dépenses du système correctionnel ont été l'un des secteurs de croissance les plus rapides dans les budgets des états. Ce poste budgétaire représentait en moyenne 7 % des dépenses des états en 2000. Il en coûte actuellement près de 40 milliards aux comtés, états et gouvernement fédéral pour emprisonner près de deux millions de personnes, comparativement à*

---

9 *Ibid.*, pages 2-4.

10 Là-dessus, voir par exemple les travaux de Wacquant, L., (2000) *Les prisons de la misère*. Paris.

11 McNamara, J.D., (2000) «Commentary : Criminalization of Drug Use. » *Psychiatric Times*, vol XVII, no 9.

5 milliards en 1978. De ce montant, vingt-quatre milliards sont dépensés pour incarcérer des délinquants non violents. Malgré la diminution modeste de la population carcérale dans les états récemment, l'augmentation massive du nombre de détenus au cours des deux dernières décennies signifie que **sur chaque quatorze dollars des fonds généraux des états un dollar a été dépensé pour le système correctionnel en 2000.** *(...) L'expansion des prisons américaines est largement due à l'incarcération de contrevenants non violents. Le pourcentage des contrevenants violents détenus dans les prisons des états est passé de 57 % en 1978 à 48 % en 1999. Entre 1980 et 1997, le nombre de contrevenants violents détenus dans les prisons des états a presque doublé (augmentant de 82 %) tandis que le nombre de contrevenants non violents a triplé (augmentant de 207 %) ; le nombre de contrevenants incarcérés pour infractions reliés aux drogues a été multiplié par 11 (augmentant de 1 040 %). »* [12]

Au Canada, comme nous le verrons au chapitre 15, alors que la criminalité globale diminue régulièrement depuis près de dix ans maintenant, la proportion d'arrestations pour infractions aux drogues n'a cessé d'augmenter et la population carcérale globale n'a pas diminué. Il est même permis de croire que la proportion des détenus présentant des problèmes reliés aux toxicomanies a en fait augmenté.

Ce discours s'est accompagné de toute une panoplie de mesures aux plans national et international, notamment l'augmentation dans divers pays des pouvoirs policiers en matière de lutte contre les drogues, le renforcement de l'infrastructure internationale des polices, l'utilisation de la lutte à la drogue dans la diplomatie internationale, et sa traduction dans les instances de l'ONU, notamment lors de la session extraordinaire des Nations Unies sur les drogues en 1998.

L'autre volet du discours porte sur l'équation drogue et criminalité. Pour une proportion importante des citoyens, l'usage des drogues est associé à la délinquance, quand il n'en est pas une cause. Témoins, ces quelques citations :

[Traduction] *« Nous ne pouvons plus continuer de mettre en œuvre des politiques et des programmes qui ne s'adressent pas aux racines de l'abus de substances et à la criminalité qui en découle.»* [13]

« Dans les pays qui ont adopté des politiques laxistes envers la consommation, les crimes violents et les activités criminelles organisées ont augmenté en proportion du commerce de la drogue. » [14]

« La situation est différente en ce qui concerne les conséquences sociales néfastes d'autres drogues illicites (que le cannabis NDLR). Dans plusieurs collectivités ou quartiers du pays, les préjudices subis par

---

12 Greene, J. et V. Schiraldi (2002) *Cutting Correctly : New Prison Policies for Times of Fiscal Crisis.* Washington, D.C. : The Justice Policy Institute. Voir aussi Schiraldi, V., Holman, B. et P. Beatty (2000) *Poor Prescription : The Costs of Imprisoning Drug Offenders in the United States.* Washington, D.C. : Justice Policy Institute. Disponible en ligne à : www.cjcj.org

13 McCaffrey, B.R., « Remarks before the First Annual Criminal Justice and Substance Abuse Conference », Albany, New York, June 29, 1999.

14 Témoignage de M Dale Orban pour l'Association canadienne des policiers et policières devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 28 mai 2001, fascicule no 3, page 49.

d'innocentes victimes de crimes avec violence et de délits contre les biens sont considérables. (...) Ces délits sont commis par des toxicomanes qui essaient de se procurer l'argent nécessaire pour assouvir leur besoin de consommation. » [15]

Profondément inscrite dans les perceptions et attitudes, cette croyance, dont on verra plus loin au chapitre 6 que les données de recherche ne la soutiennent que pour partie, s'est traduite concrètement par une série de mesures dont la création des tribunaux spéciaux sur les drogues et l'instauration d'ordonnances de traitement pour les délinquants ayant une problématique avérée de dépendance, l'expansion des programmes de tests d'urine dans les milieux de travail et dans les prisons ainsi que le remodelage des systèmes de prise en charge socio-communautaires sont des exemples.

Cette association drogues-délinquance se posait sur un terreau fertile. Pour plusieurs raisons – mutations entraînées par la globalisation et le réalignement du rôle de l'État qui expliquent au moins pour partie l'accroissement des inégalités sociales et économiques entre le Nord et le Sud mais aussi au sein des pays, tant du Nord que du Sud ; augmentation de l'insécurité des conditions de vie elles-mêmes après la fin des Trente Glorieuses (1945-1975) qui avaient connu une période sans précédent de prospérité et une sécurité de l'emploi plus grande que jamais ; fractures au sein des collectivités induites par ces incertitudes et par l'incapacité à gérer les mixités de populations – l'augmentation de la criminalité « ordinaire » (vols par effraction, vols de véhicules, vandalisme, etc.) devient la métaphore par excellence de l'insécurité des conditions d'existence. Cible facile avec sa multitude d'impacts bien réels sur la vie au quotidien dans des quartiers déjà sujets à d'autres difficultés sociales et économiques, la petite criminalité invite alors à des réponses musclées, répressives : dans tous les pays occidentaux, on voit augmenter, à partir du milieu des années 1980, le recours à l'incarcération et s'allonger la durée des peines. À cette « crise » de la sécurité collective, s'ajoute la fracture entre les générations, faisant en sorte que les jeunes deviennent comme groupe une source d'inquiétude, voire tout simplement des délinquants potentiels. Un exemple : le Canada a connu au cours de cette période une augmentation sans précédent du recours à la détention pour les mineurs, le plaçant tout au haut de la liste des pays industrialisés.[16] Quant on sait que les jeunes sont les principaux usagers de drogues, le reste de l'équation est vite établi.

Des politiques antidrogues aux politiques sur les drogues

L'arrivée du SIDA au cours des années 1980 va toutefois contribuer à une remise en question des politiques prohibitionnistes en matière de drogues illicites. On

[15] Témoignage de M Michael J. Boyd, pour l'Association canadienne des Chefs de police devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, fascicule no 14, 11 mars 2002, page 76.

[16] Là-dessus, voir entre autres Bala, N. et coll., (dir.) (2002) *Juvenile Justice Systems. An international Comparison of Problems and Solutions.* Toronto : Thompson Educational Publishing

découvre en effet, vers la fin de la décennie, que les usagers de drogues par injection intraveineuse ont un taux élevé de prévalence du VIH et d'autres pathogènes comme l'hépatite. En fait, il s'agit, après les pratiques homosexuelles et bisexuelles, de la seconde cause d'infection chez les hommes, et la seconde aussi chez les femmes hétérosexuelles.[17] Les politiques répressives, centrées sur l'interdiction de l'usage, ne permettent pas ni d'informer adéquatement les usagers ni d'adopter des mesures de réduction des risques et de prévention telles l'échange de seringues ou les sites d'injection supervisés. L'expansion des pratiques de réduction des méfaits prendra appui dans plusieurs pays sur cette nouvelle réalité.

La création d'observatoires des tendances d'usage des drogues illicites est un autre élément contribuant à la remise en question des politiques sur les drogues. Jusqu'au milieu des années 90, les USA, le Royaume-Uni et l'Australie sont à peu près les seuls pays à disposer de systèmes réguliers et répétés d'enquête épidémiologique des tendances de consommation des drogues dans les populations. À compter de 1993, l'Europe, avec la mise sur pied de l'Observatoire européen sur les drogues et les toxicomanies et la constitution du réseau d'observation des tendances dans les pays de l'Union européenne, se donne un outil fort de suivi des tendances. Or, ce système d'observation régulière aura entre autres effets celui de démontrer que les tendances d'usage de drogues ne varient pas tant selon les politiques publiques des États que selon d'autres facteurs d'ordre social, culturel et symbolique.

Enfin, un certain nombre d'États commencent à interroger leurs politiques publiques sur la base d'études d'évaluation des impacts. C'est notamment le cas de l'Australie et de la Suisse ainsi que de certains États américains. Au delà de la rhétorique souvent émotionnelle, on découvre dans ces études que les politiques, en plus d'avoir peu d'impacts sur les usages, ont des effets pervers importants et des coûts économiques élevés. Ce sont d'ailleurs les résultats de certaines études du rapport coût-efficacité qui vont amener la Californie et d'autres États américains à revoir leurs approches hautement répressives (par exemple incarcération automatique à la troisième infraction, quelle qu'elle soit).[18]

Si les législations nationales en matière de drogues illicites, notamment de cannabis, ne changent pas dans les faits, on discerne néanmoins une tendance nette à questionner les pratiques, notamment judiciaires, et à chercher des alternatives tout en respectant les Conventions internationales. C'est le cas de l'Espagne, de l'Italie, de certains états australiens, de la Belgique et plus récemment du Portugal et de la Suisse.

---

[17] Riley, D., (1998), *op. cit.*, page 14.

[18] Voir par exemple, l'étude de Rydell, C. P., et S. S. Everingham, (1994) *Controlling Cocaine: Supply vs. Demand Programs*, RAND : Santa Monica, California.

MUTATIONS AU CANADA

Nous identifions trois grandes sources de changements au Canada au cours de cette même période, qui ont des effets parfois paradoxaux, soit l'activisme judiciaire induit par l'adoption en 1982 de la Charte canadienne des Droits et Libertés, l'adoption en 1999 de la Stratégie nationale de sécurité des collectivités et de prévention du crime, et la lutte au crime organisé. Dans la mesure où nous discuterons plus amplement de chacun de ces éléments dans des chapitres ultérieurs du rapport, nous serons volontairement brefs ici, nous contentant de brosser un large contexte.

L'activisme judiciaire

Il n'est sans doute pas de meilleur exemple, en matière de cannabis, que la décision de la Cour d'appel de l'Ontario dans l'affaire Parker.[19] Dans cette affaire, les juges de la Cour d'appel ont examiné la validité constitutionnelle de la prohibition de la marijuana en vertu de la Loi réglementant certaines drogues et autres substances dans le cadre de son utilisation à des fins médicales. Les juges ont unanimement décidé que les allégations de Terrance Parker, à l'effet que cette interdiction violait ses droits fondamentaux en vertu de l'article 7 de la Charte canadienne des Droits et Libertés étaient fondées. Le juge Rosenberg, pour la majorité, a écrit que Parker a besoin de marijuana pour contrôler les symptômes de son épilepsie et que la prohibition de culture et de possession est en conséquence inconstitutionnelle. Les juges ont donc déclaré que les dispositions législatives étaient nulles et non avenues. Par contre, ils ont suspendu l'application de cette décision pour une année, donnant ainsi le temps au gouvernement d'adapter la loi en conséquence. Suite à cette décision, le Gouvernement a édicté en juillet 2001 une réglementation qui circonscrit l'usage du cannabis à des fins médicales et entamé une série d'études sur les effets précis du cannabis à des fins thérapeutiques.

D'autres décisions des tribunaux ont modifié, dans des directions diverses, l'applicabilité des dispositions de la loi en vigueur en matière de drogues, notamment sur les pouvoirs des policiers. Ces diverses décisions font l'objet d'une analyse détaillée aux chapitres 14 et 15.

Règle générale, on constate que, depuis l'adoption de la Charte, les tribunaux jouent un rôle de plus en plus important dans la vie politique canadienne, et la question des drogues n'a pas échappé à cet activisme judiciaire. D'ailleurs, une autre affaire, celle-ci portant sur l'usage du cannabis à des fins non médicales, devrait être entendue au cours des prochains mois par la Cour suprême du Canada.

---

[19] R. c. Parker 49 O.R. (3^{e}) 481

Une stratégie nationale de prévention du crime

En 1999, suite aux travaux du Conseil national de prévention du crime, le gouvernement fédéral crée la Stratégie nationale de sécurité des collectivités et de prévention du crime. Cette stratégie nationale, dotée d'abord de budgets de 35 millions $ par année, haussés à environ 65 millions $ cette année, a pour objectif de prévenir la délinquance par les actions de développement social dans les communautés en agissant notamment sur les facteurs de risque chez les enfants et chez les jeunes. Si la stratégie ne mentionne pas spécifiquement la prévention de l'usage des drogues, un certain nombre de ses projets et actions porteront rapidement sur cet enjeu, et de diverses manières.

Ainsi, le Centre juge à-propos de financer deux projets-pilote de tribunaux spéciaux sur les drogues, d'abord à Toronto puis à Vancouver, dans une visée de prévention de la récidive reliée à l'abus de drogues. De même, le Centre soutient une action de la Fédération canadienne des municipalités visant à instaurer des collectivités sans drogues dans un certain nombre de villes. Et le Centre soutient aussi l'évaluation des programmes de mesures alternatives pour les jeunes accusés de possession de cannabis.

La lutte au crime organisé

S'il est un sujet judiciaire qui a suscité beaucoup de débats publics, mené à l'adoption de nouvelles lois accordant plus de pouvoirs aux forces de police, et conduit à des opérations de police spectaculaires et à des procès non moins spectaculaires, c'est celui du crime organisé, notamment des groupes de motards criminalisés au Québec, les mafias italo-canadiennes de Montréal, et les réseaux asiatiques de l'héroïne sur la côte Ouest.

En 1995, le Parlement canadien adoptait le projet de loi C-95 afin de donner aux policiers de meilleurs outils pour faire enquête sur les personnes prenant part aux activités des gangs et intenter des poursuites contre elles. Quatre ans plus tard, trois problèmes ont incité le Gouvernement à proposer des modifications au *Code criminel* et à d'autres lois : des difficultés dans l'application de la loi, l'influence croissante du crime organisé au Canada et les activités illégales commises par des policiers lors d'opérations d'infiltration. En 1999, l'adoption du projet de loi C-51 par le Parlement fédéral (une loi omnibus modifiant le *Code criminel*), a accordé une immunité pénale aux policiers qui devaient commettre des infractions dans le cadre d'une enquête ou dans l'accomplissement d'autres fonctions pour les fins d'application de la Loi régissant certaines drogues et autres substances. Selon le gouvernement, cette modification avait comme objectif d'appuyer les policiers dans la lutte contre le crime organisé et le blanchiment d'argent.

Par ailleurs, un sous-comité du Comité permanent de la justice et des droits de la personne de la Chambre des communes a déposé, le 19 octobre 2000, un rapport proposant une série de modifications qui pourraient être apportées au *Code criminel* afin

de faciliter la lutte contre les organisations criminelles. Ce dernier était mieux connu sous le nom de Sous-comité sur le crime organisé. Il a entrepris ses travaux en avril 2000 et vue la nature du sujet soumis à l'étude, ses membres ont décidé dès le début, d'effectuer leurs travaux à huis clos. Ce Comité a entre autres recommandé de modifier le *Code criminel* de manière à en regrouper toutes les dispositions visant des activités connexes au crime organisé dans une partie spécifique qui aurait pour titre « Criminalité érigée en entreprise, infractions désignées en matière de drogue, gangs et blanchiment d'argent ». Plusieurs recommandations de ce Comité ont été reprises dans le projet de loi C-24 qui a reçu la sanction royale en décembre 2001.

UN DÉBAT DE SOCIÉTÉ

Ces considérations sur l'environnement contribuent à situer dans son contexte le débat sur les drogues. Marqué toujours au coin des enjeux de sécurité publique, le débat porte plus fondamentalement sur les bouleversements qui traversent les sociétés à travers les phénomènes de mondialisation et de globalisation. La place des drogues dans ces sociétés qui passent difficilement de la modernité à la post-modernité, tentant de réinventer le social après que la destinée individuelle, si centrale aux «révolutions » culturelles des années 60, eut remplacé le destin familial et collectif, soulève en effet des questions relatives aux frontières de l'individuel dans son rapport à l'autre et à la possibilité même de la collectivité face à la prégnance de l'individu. Comme le souligne le sociologue A Ehrenberg :

> *« (...) le drogué se présente comme le condensateur de la responsabilité incertaine. Pour les sociétés démocratiques, il est le lieu d'une interrogation sur les limites de la liberté privée, c'est-à-dire sur la tension entre le minimum de contact avec soi, sans lequel on ne peut entrer en relation avec autrui, et le minimum de distance à soi, sans lequel on ne peut pas faire société. »* [20]

C'est aussi ce que disait, d'une autre manière, le professeur B.K. Alexander, dans un texte qu'il a soumis au Comité du Sénat :

> [Traduction] *« Si l'on admet que les principes de libéralisme économique sur lesquels sont basées les sociétés occidentales produisent une dislocation des rapports sociaux, et si l'on admet que cette dislocation est l'un des précurseurs à des comportements addictifs, alors l'addiction aux drogues mais aussi à tous les substituts à la vie sociale dans nos sociétés ne sont pas la caractéristique pathologique de quelques-uns mais à des degrés divers une condition générale. Et puisque le libéralisme devient le modèle de base de la mondialisation, l'addiction est de plus en plus répandue sur la terre (...). »* [21]

---

[20] Ehrenberg, A., (1995) *L'individu incertain.* Paris : Calman Lévy, page 163.

[21] Alexander, B.K., (2000) « The globalization of addiction. » *Addiction Research*, vol. 8, no. 6, page 504.

La question des drogues, on le voit, ne peut simplement se poser en termes de pénalisation ou dépénalisation, car elle renvoie à des enjeux de société beaucoup plus profonds, tenant au rôle du gouvernement de soi dans un contexte où le gouvernement politique de la collectivité est en mutation, et au rapport entre les deux. Réduire la question des drogues à un enjeu de législation pénale plus ou moins répressive ou plus ou moins libérale, c'est faire l'économie d'interrogations plus larges et c'est faire le jeu des intérêts particuliers d'institutions qui ont intérêt à réduire la figure du drogué à l'autre, au déviant, au pathologique, et les drogues aux seules drogues illicites, alors que les figures de la drogue sont multiples et diverses. Comme le soulignait d'ailleurs le rapport de l'Organe international des stupéfiants pour 2000, le trafic de médicaments psychoactifs et l'augmentation de leur consommation sont, à bien des égards, des phénomènes beaucoup plus préoccupants que le marché des drogues illicites. Il y a grand risque à prendre la pointe de l'iceberg pour l'iceberg dans son ensemble et à se laisser dériver ainsi sur des continents aussi simplificateurs qu'ils sont dangereux pour une véritable politique publique en matière de drogues.

PARTIE II

LE CANNABIS : EFFETS, USAGES, ATTITUDES

CHAPITRE 5

LE CANNABIS : DE LA PLANTE AU JOINT

Cannabis, marijuana, pot, herbe, kif, grifa, ganja, autant de cultures, autant de manières de nommer la drogue issue du *cannabis sativa indica*, l'une des deux principales variétés du chanvre. Il ne s'agit pas uniquement de dénominations mais aussi des modes d'utilisation et des contextes d'usages différents : ici, la mari est roulée dans un papier avec du tabac à cigarette (joint), là le kif sera fumé à la pipe, et là encore le *ganja* sera fumé dans une pipe à eau. Elle est parfois incorporée à des biscuits ou à des gâteaux. Le pétard, le joint ou le *bangh* indien sont des manières de nommer le produit consommé et désignent en même temps des usages différents : la mari est le plus souvent composée des sommités fleuries et de feuilles séchées réduites en poudre ; la *sinsemilla* est une préparation de sommités femelles d'une variété privée de graines tandis que la ganja indien est composé uniquement de sommités fleuries fécondées.[1]

Ces appellations ne sont pas de simples accidents folkloriques : comme pour d'autres substances, le cannabis a ses usages codifiés variables selon les cultures. Les mots utilisés pour nommer la même drogue renvoient à un ensemble de rapports qu'entretiennent les populations de diverses cultures avec elle, une sorte de code des manières mais aussi des raisons de consommer. En Amérique (États-Unis et Canada), la mari a longtemps été identifiée à la jeunesse et à la libération sexuelle des années 60 ; en Inde ou en Jamaïque, le *ganja* a des dimensions religieuses qu'il n'a pas nécessairement en Occident ; et cette drogue, la même pourtant, a d'autres significations culturelles encore au Maghreb. Nous y reviendrons au chapitre 7.

Ce chapitre décrit d'abord la plante et les variantes sous lesquelles elle devient une drogue de consommation. Il examine ensuite brièvement l'origine géographique de la plante de cannabis et les circuits contemporains de sa circulation, notant au passage les modes actuels de production sous serre et hydroponique qui se sont développés dans certaines régions du Canada. Il décrit ensuite la pharmacocinétique de la plante de cannabis, notamment ses principaux composants actifs et leur métabolisme dans le corps.

---

[1] Voir notamment INSERM (2001) *Cannabis. Quels effets sur le comportement et la santé ?* Paris : Les Éditions Inserm, page 143 passim ; ben Amar M. « Le cannabis » (sous presse) ; Wheelock, B.B. (2002) *Physiological and Psychological Effects of Cannabis : review of the Findings.* Rapport préparé pour le Comité spécial du Sénat sur les drogues illicites, Ottawa : Sénat du Canada.

UNE PLANTE, DIVERSES DROGUES [2]

Il existe plusieurs variétés de cannabis. Les plus connues sont *Cannabis sativa, Cannabis indica* et *Cannabis ruderalis*. Le *Cannabis sativa* est la principale variété qui pousse sous presque tout climat. Dans des sols secs, sablonneux et légèrement alcalins il fournit des plants pouvant atteindre jusqu'à sept mètres de hauteur. Au Canada, c'est le *Cannabis indica* qui est préférablement cultivé en sol. Il fournit des plants plus courts, mais plus concentrés en Δ^9-THC (le principal composant actif du cannabis discuté plus amplement plus loin). Il existe des plants mâles et femelles. En général, les plants femelles sont plus riches en Δ^9-THC que les mâles, qui sont souvent plus dégarnis et plus petits. Le Δ^9-THC se trouve surtout dans une résine que sécrètent les extrémités florales.

Têtes de plants et feuille de cannabis

Il semble que le cannabis a d'abord été connu en Chine il y a environ 6 000 ans. On en trouve ensuite en Inde, puis au Moyen-Orient, en Afrique, au Mexique et en Amérique du Sud. La culture du cannabis peut prendre plusieurs formes. Parfois, la culture est pratiquée dans des serres ou en culture hydroponique, ce qui permet d'augmenter la productivité des plants et d'obtenir des teneurs élevées en Δ^9-THC. Les méthodes de sélection génétique des meilleures variétés et de cultures sous serre ont aussi permis d'augmenter le contenu en principe actif.

---

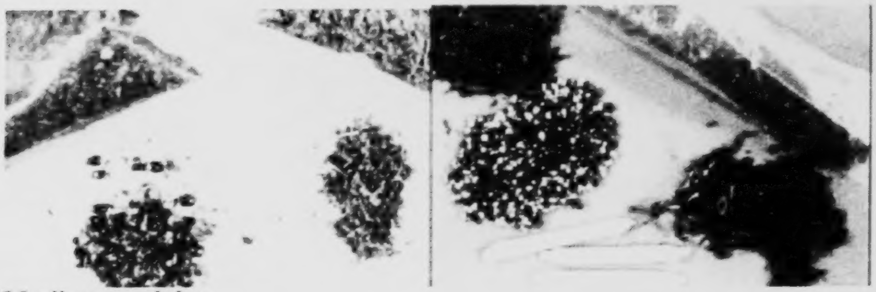
[2] Cette section s'inspire librement des divers travaux, notamment ceux de Ben Amar (sous presse), de l'INSERM, *op. cit.*, et de la Conférence scientifique internationale sur le cannabis (2002). Nous tenons à remercier notamment le professeur Ben Amar de nous avoir permis de reproduire les planches.

Plants de cannabis mâles et femelles

Terme mexicain employé initialement pour parler de tabac à bon marché, mais qui plus tard désigne certaines parties de la plante du cannabis, la *marijuana* est généralement de couleur verte ou brune et dégage une odeur caractéristique lorsqu'elle brûle. Son apparence ressemble à l'origan ou au thé haché.[3] La marijuana provient de l'ensemble des parties de la plante qui ont été séchées. Sous cette forme, son contenu en THC est inférieur ; il augmente notamment en sélectionnant les extrémités florales du plant femelle. Ainsi séchée et réduite en une poudre grossière, la marijuana est le plus souvent roulée en cigarettes fines avec du tabac à cigarette dans la plupart des cas (joint), parfois fumée aussi à l'aide d'une pipe ou moins fréquemment sous forme de cigares. Un joint typique contient entre 0,5 et 1 g de cannabis. On peut aussi, comme pour le haschich, l'inclure dans des préparations de biscuits et de gâteaux. Il sera aussi bu sous forme d'infusions. Certains nous ont dit que la production contrôlée, sous serre, de cannabis domestique coûte environ 100 $ l'once, qui sera ensuite vendu à un prix moyen variant entre 200 $ et 250 $ sur le marché. Cette estimation du coût de production nous semble largement exagérée. Par contre, les seules autres études disponibles portent sur les coûts de production dans des pays en développement, tels le Maroc.

---

[3] Sur ces questions voir notamment : McKim W.A. (2000) «Cannabis ». in McKim, W.A. (ed.) *Drugs and Behavior. An introduction to behavioral pharmacology*. Upper Saddle River : Prentice Hall. ; Santé Canada (1990) *Les drogues. Faits et méfaits.*. Ottawa : Ministère des approvisionnements services ; et Comité permanent de lutte à la toxicomanie (2001) *Drogues. Savoir plus. Risquer Moins.* (Édition québécoise). Montréal : Stanké.



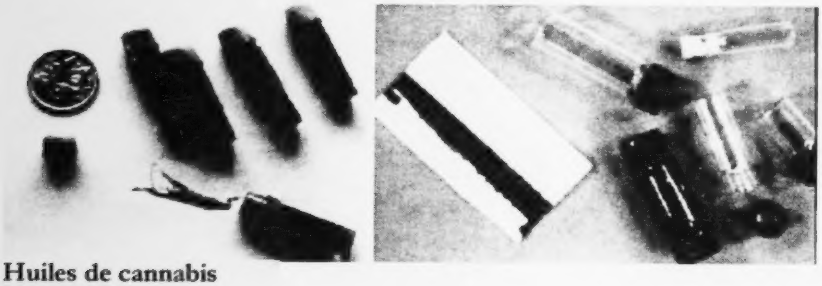
Marijuana et joints

Le *haschich*, ou encore haschich, aussi connu sous l'appellation de hasch, shit, kif (en Afrique du Nord) ou *charas* (en Inde), résine visqueuse produite par la plante et obtenue par battage des feuilles et des sommités florales sèches qui est ensuite compressée pour obtenir ce qu'en France on appelle une barrette, ici un cube ou un bloc. Il faudra environ 45 à 75 kg de cannabis pour produire un kilo de haschich. Il se présente sous forme de morceaux de couleur brun pâle à noir, de consistance molle ou dure. Il est fréquemment fumé, seul ou mélangé au tabac ou à la marijuana, sous forme de cigarette (joint), à l'aide d'une pipe ou plus rarement sous forme de cigare. Il peut aussi être inclus dans des biscuits ou des gâteaux. La teneur en Δ^9-THC du haschich est généralement comprise entre 3 et 6 % lors d'une production normale. De même que pour le cannabis, le contenu en Δ^9THC sera augmenté par les méthodes de culture et par la concentration de résine, pour atteindre en production moyenne des teneurs de plus de 10 %. Légèrement plus dispendieux que la marijuana, le haschich se vend environ 300 $ à 350 $ l'once sur le marché.

Haschich

Il existe deux autres produits issus du cannabis, les huiles de marijuana et de haschich, extraites de la résine par de l'alcool à 90^0 évaporé par la suite par exposition au soleil. Il s'agit d'un liquide visqueux, brun-vert à noirâtre, d'odeur vireuse. Les huiles sont généralement plus concentrées en cannabinoïdes, pouvant atteindre des

teneurs de 30 à 60 % en Δ^9-THC. Les huiles sont généralement déposées sur le papier à cigarettes ou imprégnées dans du tabac puis fumées. Les huiles sont plus rares et plus dispendieuses.



Huiles de cannabis

L'extrait qui suit, tiré d'un rapport préparé par MM Labrousse et Romero pour l'Observatoire français des drogues et des toxicomanies en 2001 sur la production de cannabis au Maroc, décrit très bien les diverses étapes de production.

Du cannabis à l'huile – processus de fabrication au Maroc

Le kif est le nom donné au plan de cannabis entier. (…) Coupé et séché au soleil (en général sur les toits) pendant au moins un mois et demi, il est conservé dans les maisons pendant plusieurs mois sous la protection de bâches en plastique. Haché à la main sur une planchette à l'aide d'un couteau spécial, il sera mélangé à du tabac pour être fumé. Traditionnellement, le mélange comprend 1/3 de kif et 2/3 de tabac. Il est fumé dans le *sebsi*, longue pipe en bois au fourneau de terre cuite ou de pierre.

La *chira* est la poudre résultant de la solidification des gouttelettes de résine exsudant des sommités des plantes femelles. Pour séparer la résine des plants séchés, les transformateurs battent ou secouent ces derniers au-dessus d'un fin voile de nylon tendu qui fait office de tamis. La première poudre qui tombe, de couleur beige-doré, est appelée *sigirma*. C'est la première qualité, dite double-zéro, réputée contenir jusqu'à 20 % de THC. Ensuite tombe une poudre nommée *hamda*, mêlée de déchets végétaux qui lui donnent une couleur verdâtre. Cette *hamda* est plus ou moins tamisée, pour donner différentes qualités de produit : zéro, no1, no2, no3, et no4 (la plus médiocre), contenant respectivement de 10 à 2 % de THC. (…) Il faut environ 100 kilos de kif pour obtenir un kilo de haschich de première qualité.

Les paysans (…) nous ont indiqué que la suite des opérations, lorsqu'elle est réalisée par des trafiquants, se déroulait dans des bâtiments isolés dans la montagne censés être secrets. (…) Là, mise dans des sachets de cellophane, la poudre est chauffée et compressée, pour donner la résine ou haschich, destinée à la commercialisation, présentée sous forme de savonnettes ou de plaquettes (généralement de 250 grammes) appelées *tbisla* ou « petit plateau ». (…) La qualité « double zéro » qui tire son nom des deux trous faits sur la tablette avec le bout incandescent d'une cigarette, est réservée à la consommation intérieure et aux clients privilégiés. Les clients étrangers, mal informés, n'ont souvent droit qu'à du haschich fortement coupé de cirage noir, colles, henné, figue, terre, voire médicaments.

(…) L'huile de cannabis est obtenue à partir des résines de qualité no3 et no4. On la fabrique en délayant le haschich dans un récipient d'alcool pharmaceutique. Après distillation pendant 6 à 8 heures, le liquide est filtré et remué jusqu'à évaporation complète de l'alcool. La production locale de ce liquide à haute valeur ajoutée (il faut 10kg de haschich pour obtenir un litre d'huile) est moins marginale qu'on ne le pense généralement.

Labrousse, A. et L. Romero (2001) *Rapport sur la situation du cannabis dans le RIF marocain.* Paris : OFDT.

ROUTES DU CANNABIS

D'où proviennent le cannabis et le haschich disponibles au Canada ? Quelles quantités sont importées et produites localement ? Quelles sont les routes de circulation entre provinces ? Quelles quantités sont exportées vers d'autres pays ? Quelle est la valeur financière de ce marché ? Ces questions reviennent constamment dans l'esprit de chacun, de même que dans les discours. Elles servent qui à souligner l'ampleur du problème des drogues généralement, qui à expliquer la puissance du crime organisé qui en tire ses revenus, qui encore à justifier le décalage entre l'importance du problème et les ressources limitées que consacrent les États à la réduction de l'offre. Mais ces données peuvent aussi aider à mieux saisir l'ampleur des difficultés que vivent les paysans dans les divers pays producteurs, les enjeux écologiques que pose la culture des drogues, de même que le positionnement stratégique des drogues dans la géopolitique mondiale.

La culture du cannabis est la plus répandue de toutes les drogues illicites ; pas étonnant dans la mesure où non seulement la plante pousse librement sous plusieurs climats, mais où elle demande aussi peu de transformations avant de devenir marijuana. Selon le rapport 2000 du *Programme des Nations Unies sur le contrôle des drogues* (UNDCP) :

> [Traduction] *« Au cours de la dernière décennie, 120 pays ont rapporté la culture illicite de cannabis sur leur territoire. À partir des saisies faites en 1998 Interpol a identifié 67 pays source de cannabis. (…) Il est beaucoup plus difficile d'estimer l'étendue des cultures illicites, de la production et du trafic de cannabis que pour d'autres plantes productrices de drogues en raison de la grande quantité de cannabis sauvage, de la diversité des méthodes de culture et de l'ampleur du trafic. Contrairement à d'autres drogues issues de plantes, les produits du cannabis peuvent provenir de trois sources qualitativement distinctes de production : les cultures extérieures illicites, les plantations sauvages exploitées et les cultures intérieures utilisant une technologie sophistiquée. (…) Le nombre de pays ayant rapporté une augmentation de la consommation de cannabis (deux-tiers de tous les pays ayant fourni des statistiques sur l'abus de drogues en 1996) indique que la production globale aurait augmenté ; mais les données de saisies ne confirment cette hypothèse qu'en partie. (…) Les estimations de la culture de cannabis (incluant les cultures sauvages) à partir des rapports des États membres au cours des années 1990 sont entre 670 000 et 1 850 000 hectares. Les estimations de production varient selon un facteur de 30, entre 10 000 et 300 000 tonnes. Reliant les estimations de production et de consommation, UNDCP estime que la production de cannabis dans le monde est d'environ 30 000 tonnes. »* [4]

On constate la grande variabilité des estimations et la difficulté immense de les valider. Comment en effet, estimer la quantité de plants de cannabis qui sont transformés en marijuana ? Les données produites par les gouvernements de divers pays sur les surfaces cultivées ne sont elles-mêmes que des approximations. Quant à

[4] United Nations Office for Drug Control and Crime Prevention (2001) *World Drug Report 2001*. Oxford : Oxford University Press, pages 30-32. Disponible en ligne à http://www.undcp.org/adhoc/world_drug_report_2000/report_2001-01-22_1.pdf

Variabilité des estimations – le cas du Maroc

L'étude de Labrousse et Romero indique que, selon le Ministère de l'Agriculture, les surfaces de production de cannabis toucheraient 75 000 hectares en 2000. (Par comparaison, le rapport 2000 de l'ODCCP cite le chiffre de 50 000 hectares de production de cannabis au Maroc, chiffre fourni officiellement par le Ministère de l'intérieur.)

Leur propre travail sur le terrain propose des superficies de 90 000 hectares pour 1999 et entre 100 000 et 120 000 pour 2001. Cette production concernerait environ 200 000 familles, soit entre un million et un million et demi de personnes. Pour une telle superficie, la production, une fois déduit le kif consacré à la consommation nationale, serait entre 1 600 et 3 000 tonnes.

Labrousse et Romero, *op. cit.*

savoir combien de serres et autres formes de production intérieure existent, il n'y a à proprement parler, aucun moyen de le savoir.

Les travaux de l'équipe de l'Observatoire géopolitique des drogues en France sous la direction d'Alain Labrousse demeurent exemplaires en la matière. L'encadré ci-contre, tiré du même rapport produit pour l'OFDT en 2001, fait état d'un travail terrain de trois mois où les auteurs ont procédé au recoupement de données provenant de sources diverses.

On constate surtout que, lorsque relié à la population des consommateurs potentiels de cannabis (que l'Office estime à environ 120 millions de personnes), l'estimé de production globale à 30 000 tonnes est beaucoup plus près du plancher de 10 000 tonnes que du plafond de 300 000.

Selon UNDCP, les principaux producteurs sont la Colombie et le Mexique pour la marijuana, le Maroc pour le haschich. Selon l'organisation internationale de police criminelle (Interpol) le Maroc, l'Afghanistan et le Pakistan sont les principaux pays sources de haschich et la Colombie, le Niger et l'Afrique du Sud de cannabis. Enfin, selon Labrousse, les productions de marijuana explosent, la Colombie redevenant le grand producteur qu'elle était dans les années 1970, les productions progressant rapidement en Afrique de l'Ouest (Nigeria, Ghana, Congo, Côte d'Ivoire, Sénégal), cependant que les grandes plaines de la CEI (Kazakhstan, Kirghizistan, Ukraine, Biélorussie et Azerbaïdjan) représentent un potentiel d'exportation quasi illimité, tandis que l'Afghanistan et le Pakistan produisent probablement 2000 tonnes de haschich, l'équivalent de la production marocaine.[5] Par ailleurs, le Canada lui-même est l'un des pays exportateurs de cannabis depuis plusieurs années déjà.[6]

Traditionnellement, le cannabis disponible au Canada provenait principalement du Mexique, de la Jamaïque, et de pays du cône sud de l'Afrique, tandis que le haschich provenait principalement de l'Asie et du Moyen Orient :

> *« Le marché du haschich dans le centre et l'est du Canada est connu dans le monde entier. Les criminels américains sont parmi les trafiquants internationaux qui orchestrent des envois de plusieurs tonnes de*

[5] Labrousse, A. (2000) *Drogues. Un marché de dupes.* Paris : éditions alternatives ; voir aussi : « L'approvisionnement des marchés des drogues dans l'espace Schengen. » *Les Cahiers de la Sécurité Intérieure*, 32, 2e trimestre 1998.

[6] Cité dans OGD (1996) *Atlas mondial des drogues.* Paris : PUF.

cette drogue du Pakistan à destination de Montréal par navire ravitailleur ou par conteneur. En 2001, des envois ont transité par les Émirats arabes unis, l'Afrique et l'Europe avant de parvenir au Canada. On importe également des chargements de plusieurs kilos de la Jamaïque par le biais de passeurs voyageant à bord de vols commerciaux. » [7]

Si une large partie du cannabis en vente sur le marché canadien était d'origine étrangère jusqu'aux années 1980 environ, la situation s'est fortement modifiée depuis. On estime en effet que la production nationale a maintenant supplanté les importations. Ainsi, le rapport de la Gendarmerie Royale du Canada pour 1999 fait état de ce qui suit :

« On estime que plus de 50 % de l'approvisionnement de marihuana au Canada est produit au pays. En ce qui a trait à la marihuana de l'étranger saisie au Canada ou en route vers le Canada en 1999, au moins 5 535 kilos provenaient de la Jamaïque, 825 kilos de l'Afrique du Sud et 860 kilos du Mexique. Les envois de l'étranger sont expédiés directement au Canada ou via les États-Unis. Le 11 juin 1999, à Newark (New Jersey), le service des douanes des États-Unis a intercepté 2 464 kilos de marihuana de la Jamaïque et 141 kilos d'huile de cannabis dans un conteneur maritime en partance pour Montréal. De plus, le 20 juin 1999, à Stuart (Floride), on a saisi 2 617 kilos de marihuana de la Jamaïque, qui était destinée au Canada, dans le cadre du projet JOULE. » [8]

Combien de cannabis et de haschich sont disponibles au Canada ? Quelle est la valeur économique de ces drogues ? Il est en fait impossible de répondre à ces questions, pour des raisons évidentes, ces drogues étant illégales. Alors qu'on connaît la quantité de tabac produit et vendu sous forme de cigarettes, alors qu'on sait quel est le volume d'alcool produit ou importé et consommé, et que dans les deux cas on peut traduire ces volumes en chiffres d'affaires, il est impossible de le faire pour les drogues illicites.

Pendant un certain temps, le Programme des Nations Unies sur les drogues avançait que la valeur totale de « l'industrie » des drogues illicites équivalait à 400 milliards $ US, soit une valeur plus élevée que l'industrie pétrolière.[9] De ce montant, on ne peut évidemment extraire la valeur du cannabis, même si l'on sait par ailleurs que la consommation de cannabis concerne le plus grand nombre de personnes. Comment, sur quelle base, avance-t-on ces chiffres, personne ne le sait vraiment. S'ils ont été produits à partir d'une méthode rigoureuse de calcul ou s'ils ont été lancés au hasard d'un repas sur le coin de la nappe, nous l'ignorons.[10] Pourtant, ces chiffres servent souvent de référence. Ainsi, le très sérieux magazine britannique *The Economist*

---

[7] Gendarmerie Royale du Canada (2002) *Situation au Canada – Drogues illicites (2001).* Ottawa : Direction des renseignements criminels - GRC.

[8] Gendarmerie Royale du Canada (2000) *Situation au Canada – Drogues illicites (1999).* Ottawa : Direction des renseignements criminels - GRC.

[9] PNUCID, (2000) *op. cit.*

[10] Le Comité a invité le Directeur exécutif du PNUCID ou un délégué à venir témoigner devant lui mais a essuyé un refus.

dans une série d'articles publiés en 2001 sur la question des drogues illicites, citait ce montant avant de proposer une estimation plus conservatrice à environ 150 milliards $US.[11] Par comparaison, la valeur de l'industrie pharmaceutique avoisine les 300 milliards $, celle du tabac est de 204 milliards $ et celle de l'alcool de 250 milliards.

Puisque les auteurs détaillent leurs méthodes de calcul, poursuivons l'analyse de l'exemple marocain.

Rendements et rapports du cannabis – le cas du Maroc

Le cannabis est une plante peu exigeante qui pousse sur des sols de mauvaise qualité, mais qu'il contribue assez vite à rendre inapte à toute forme d'agriculture. Le caractère illégal de cette culture fait que les revenus qu'elle procure sont sans commune mesure avec les cultures vivrières ou de rente légale. En outre, c'est un produit non périssable, que l'on peut écouler à domicile, toujours sûr de trouver un marché, permettant la vente à crédit, etc. Il permet notamment l'amélioration des conditions d'habitat de la population et l'ouverture de route sur l'initiative des paysans eux-mêmes.

L'estimation des revenus du cannabis à l'hectare varie en fonction des sols, de la pluviométrie, du fait qu'il soit irrigué ou non, transformé ou non en chira (poudre), de la période de la vente, etc. En outre, pour les mêmes critères on trouve des estimations différentes de la part des chercheurs. Cela est dû au fait qu'il est difficile d'obtenir de la part des paysans, du fait de leur méfiance, des données fiables. En ce qui concerne la production du kif non transformé, le revenu varie, selon les sources, de 12 450 F (francs français) à 210 000 F à l'hectare.

(…) si le cannabis est très rentable sur des périmètres irrigués, il l'et beaucoup moins sur des terrains pluviaux, surtout les mauvaises années. (…) De nombreux paysans ne cultivant vraisemblablement que de 1,5 ha à 3 ha (non irrigués) de cannabis, ne retirent, les mauvaises années, que de 20 000 F à 40 000 F de cette culture pour faire vivre des familles qui dépassent souvent dix personnes.

(Mais) le cannabis est 12 à 46 fois plus rentable que les cultures de céréales.

En tablant sur une production de 1 397 tonnes de haschich pour l'ensemble du Rif, Pascual Moreno estimait en 1997, le rapport pour les producteurs marocains (du paysan au grand trafiquant) à 1 816 millions $. Étant donné qu'un certain nombre de trafiquants marocains opèrent à l'étranger, Pascual Moreno estime à 2000 millions $ le retour des profits du cannabis dans l'économie marocaine, contre 750 millions $ pour les exportations de textile ; 460 millions pour les investissements à l'étranger et 1 260 millions pour le tourisme. Le même auteur estime à 3 milliards $ les bénéfices des trafiquants européens (ce calcul n'inclut apparemment pas la vente de rue).

La culture du cannabis étant cependant plus rentable que toute autre culture, les paysans tendent à abandonner les cultures vivrières pour s'approvisionner sur le marché. Le résultat est que la région devient déficitaire en aliments.

Labrousse et Romero (2001) *op. cit.* : 12-15.

Nous ne connaissons pas de travail terrain équivalent pour le Canada ni même le Mexique. De plus, au Canada, les conditions climatiques ont stimulé le développement des cultures en serre et hydroponique, et on ignore quel serait le rapport entre ces méthodes de culture et les cultures en sol.

Nous usons donc des chiffres et des données qui suivent sur la production de cannabis, l'importation de cannabis et de haschich, et la valeur économique de ces drogues sur le marché canadien, avec beaucoup de réserve et de prudence.

[11] « Stumbling in the Dark », *The Economist*, July 28 – August 3, 2001.

Selon la GRC « *la production annuelle de marihuana au Canada serait d'au moins 800 tonnes. Ce chiffre semble exagéré, mais les enquêteurs croient plutôt qu'il est très conservateur si l'on se fie aux renseignements recueillis et aux saisies de plantes de marihuana et de marihuana en vrac qui ont été effectuées. En 1999, les services de police canadiens ont saisi environ un million de plantes*.»[12] Les rapports pour 1998 et pour 2002 font état des mêmes chiffres. Notons aussi qu'à 800 tonnes, la production canadienne équivaudrait à environ 2,5 % de la production mondiale si on retient le niveau proposé par le PNUCID.

En ce qui a trait à la valeur du marché le rapport annuel 1998/1999 de l'Observatoire géopolitique des drogues rapportait, selon des sources policières, que le marché des drogues illicites au Canada représentait annuellement de 7 à 10 milliards $.[13] Pour 2001, la GRC estime que la valeur du marché de l'ensemble des drogues illicites serait de 18 milliards $![14] Il est impossible d'estimer la part que représentent le cannabis et le haschich dans ce total. Comme nous ignorons le plus souvent la base de calcul de ces estimations, elles doivent aussi être considérées avec prudence. Comme l'a mentionné le Sous-solliciteur général adjoint lors de sa comparution devant le Comité, les méthodes de calcul, basées sur l'hypothèse que les organisations policières et douanières saisissent 10 % des drogues, n'ont rien de scientifique et sont peu fiables.[15] Nous relevons néanmoins une incohérence apparente : la stagnation apparente de la production de cannabis à 800 tonnes et de l'importation de haschich à 100 tonnes, depuis 1998, de même que la baisse des prix de l'héroïne et de la cocaïne dans un marché stable voire en diminution (rapports de la GRC) ne concordent pas avec le doublement présumé de la valeur totale du marché des drogues. De fait, lorsqu'il faisait face à ces diverses estimations sur la quantité produite et sur la valeur économique de ce marché, le Comité avait souvent l'impression qu'au fond personne ne sait vraiment quelle en serait la taille.

En ce qui concerne le haschich, la GRC estime qu'il

> « *(...) est plus facile d'estimer la quantité de haschich parvenant sur le marché canadien annuellement que celle de toute autre drogue illicite. En effet, contrairement à ce que l'on observe pour d'autres drogues, comme la cocaïne et la marihuana, que l'on peut trouver partout au Canada et aux États-Unis, la consommation de haschich, en Amérique du Nord, est un phénomène localisé. Cette drogue est fort populaire au Québec, en Ontario et dans les provinces de l'Atlantique, alors que la demande est restreinte ailleurs au Canada et que l'approvisionnement est au mieux sporadique dans le nord-est des États-Unis. Par conséquent, des groupes de criminels organisés de Montréal se sont spécialisés dans l'importation massive de haschich et exercent un monopole sur sa distribution en gros. Compte tenu de ces faits, et des renseignements sur les arrivages de plusieurs tonnes de haschich saisis au Canada et à*

---

[12] Gendarmerie Royale du Canada (2000), *op. cit.*

[13] Observatoire géopolitique des drogues (1999) *Rapport annuel 1998/1999.* Paris : OGD, page 178.

[14] Greater Toronto Area Combined Forces Special Unit (2002) *Fact Sheet – Heroin.* Disponible en ligne à l'adresse : http://www.cfseu.org/heroin.html

[15] M. Paul Kennedy, Témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, fascicule, 10 juin 2002.

l'étranger et sur ceux dont on sait qu'ils sont entrés sur le marché canadien, des analystes de la GRC estiment qu'au moins 100 tonnes de cette drogue sont importées au Canada chaque année. » [16]

Par ailleurs, le Canada est aussi une terre de transit de drogues vers les États-Unis et une partie importante du cannabis canadien est destiné à l'exportation, notamment vers les États-Unis.

« Les autorités de part et d'autre de la frontière s'inquiètent de l'introduction aux États-Unis de marihuana du Canada. Bien que cette activité soit particulièrement perceptible à la frontière entre la Colombie-Britannique et les États-Unis, elle ne se limite pas à cette province. Selon les renseignements recueillis, les Hell's Angels du Québec approvisionnent leurs homologues américains. On a également établi que de la marihuana est passée en contrebande par les Grands Lacs. Toutefois, en 1999, il y a eu peu de saisies de marihuana aux États-Unis où l'on a pu déterminer que la drogue provenait du Canada. » [17]

En 1999, des fonctionnaires de Washington avaient laissé entendre que le Canada pourrait être placé sur la liste des pays soupçonnés de faire preuve de laxisme dans la lutte contre la production et le trafic des drogues. Plus récemment, des fonctionnaires de la *Drug Enforcement Administration* ont répété que le trafic de cannabis du Canada vers les États-Unis représentait un problème significatif. Un agent de la GRC confiait à un journal national qu'environ 70 % de la marijuana cultivée au Canada aboutissait aux États-Unis[18] tandis que le rapport de l'Organe international de contrôle des stupéfiants pour 2000 parlait d'environ 60 %.[19] Nous avons entendu dire, et des agents de la GRC nous ont aussi dit, que le cannabis de Colombie-Britannique avait une telle valeur qu'il s'échangerait au pair avec la cocaïne. En effet, selon ces policiers spécialisés dans la lutte contre les stupéfiants, le cannabis de qualité triple A de Colombie-Britannique vaudrait environ 4 000 $ la livre au Canada et le kilogramme de cocaïne vaudrait 11 000 $ US actuellement. Toutefois, le rapport annuel pour 1999, s'il fait allusion à cette supposition, ne la confirme pas :

« La marihuana canadienne est parfois utilisée comme monnaie d'échange pour acheter de la cocaïne entreposée aux États-Unis. Les échanges se font approximativement dans un rapport de 3 contre 1. Des rumeurs d'échange de 1 contre 1 courent, mais aucun cas n'a pu être confirmé. De plus, cette proportion n'est pas logique d'un point de vue commercial sachant qu'un kilo de cocaïne se vend 13 000 $ US (en chargements de 50 kilos ou plus) alors que le prix de gros d'un kilo de marihuana se situe entre 6 000 $ US et 8 000 $ US. D'autres trafiquants canadiens transportent de la marihuana

---

16 *Ibid.*

17 Gendarmerie Royale du Canada (2000) *op. cit.*

18 National Post, 17 mai 2002. Le Comité note avec intérêt – et un certain amusement – que cet article et un reportage précédent du réseau Global du 13 mai 2002 faisant état des préoccupations de représentants américains, faisaient suite à la publication par le Comité de son Document de discussion.

19 Organe international de contrôle des stupéfiants (2001) *Rapport de l'Organe international de contrôle des stupéfiants pour 2000.* Disponible en ligne à http://www.incb.org

(en chargements de 20 kilos à 50 kilos) aux États-Unis qu'ils vendent à des acheteurs locaux. Avec les produits de ces ventes, ils achètent de la cocaïne avant de rentrer au pays afin de l'écouler sur le marché canadien. » [20]

Quant au rapport annuel de la GRC pour 2002, il se contente de mentionner la pratique de l'échange de cannabis canadien contre la cocaïne, sans préciser s'il s'agit d'un échange poids pour poids. Nous relevons ici aussi une certaine incohérence puisque le kilo de cocaïne est exprimé en dollars US tandis que celui de la marijuana est tantôt en dollars canadiens tantôt en dollars américains.

Au pays, les principaux producteurs sont la Colombie-Britannique, l'Ontario et le Québec. On peut imputer l'importance de la production de la Colombie-Britannique notamment aux conditions climatiques propices. Mais cette explication est courte. Il faut probablement y ajouter des explications d'ordre socio-culturel, la mentalité particulière de la côte pacifique contribuant à expliquer pour partie pourquoi le cannabis semble y avoir pris racine de façon plus significative.

La production de cannabis en Colombie-Britannique aurait augmenté significativement au cours des 10 dernières années, devenant selon certains analystes l'une des industries les plus importantes de la province en termes de sa valeur économique. Certains analystes en chiffrent la valeur à 6 milliards $, tandis que selon certains policiers, une estimation conservatrice la placerait à hauteur d'environ 4 milliards $![21] Permettons-nous un calcul : si la marijuana se vend 225 $ l'once, à 16 onces par livres, la Colombie-Britannique produirait l'équivalent de 550 tonnes de cannabis par année, soit plus des deux-tiers de la quantité totale de cannabis circulant en territoire canadien.

Par ailleurs, témoignant devant le Comité spécial lors d'une audience publique à Richmond, C.-B., le 14 mai 2002, le surintendant Clapham de la GRC parlait de l'existence de 15 000 à 20 000 lieux de production illégale de cannabis en Colombie-Britannique (chiffres provenant de la *Drug Enforcement Administration*), tandis que des spécialistes en stupéfiants de la GRC faisaient état le lendemain de 7 000. Quel que soit le nombre le plus près de la réalité, les chiffres, on le voit, doivent nécessairement être pris avec beaucoup de prudence.

Quant aux méthodes de culture, la production en sol demeurerait encore la plus populaire, mais les méthodes de culture plus sophistiquées, hydroponique et aéroponique[22] notamment, seraient en expansion, notamment chez les gangs criminalisés disposant de l'infrastructure nécessaire.

« Il arrive souvent qu'on découvre des installations où l'on cultive à l'intérieur plus de 3000 plantes. Bien que les statistiques diffèrent considérablement d'une province à l'autre, dans l'ensemble, moins de 10 % de la marihuana saisie au Canada provient d'une culture hydroponique (méthode selon laquelle les

---

[20] Gendarmerie Royale du Canada (2000) *op. cit.*

[21] GRC, rencontre privée.

[22] Technique où les racines sont suspendues et vaporisées régulièrement avec de l'eau enrichie en matières nutritives, encore très rare et dont il reste à en démontrer l'efficacité. (Source : GRC (2002)).

plantes poussent dans des solutions minérales nutritives plutôt que dans le sol). Si l'on fait encore beaucoup appel aux méthodes de culture organique dans le sol pour les installations intérieures, la culture hydroponique gagne en popularité. Malgré l'existence de technologies de pointe visant à accroître la production, la plupart des cultivateurs de marihuana ne se donnent pas la peine de les utiliser, leur préférant des méthodes plus simples et éprouvées. La marihuana demeure la drogue illicite de choix, tant du point de vue du trafic que de la consommation. On évalue la production annuelle de marihuana à cinq millions de plantes. Étant donné qu'il est relativement peu coûteux de mettre sur pied une culture et que les profits réalisés sont considérables, cette activité est de plus en plus intéressante, même pour les citoyens normalement respectueux des lois. Dans la plupart des régions, les installations d'envergure sont immanquablement l'œuvre des bandes de motards hors-la-loi, bien que des organisations de souche asiatique jouent un rôle croissant en Colombie-Britannique et en Alberta. De plus en plus de groupes emploient des « garde-récoltes » et autres intermédiaires pour surveiller leurs plantations. Cette approche fait en sorte que la police a du mal à établir des liens entre l'activité et les véritables responsables. Les cultures extérieures sont souvent installées sur des terres publiques, dans des coins isolés, afin de réduire les risques de détection. « [23]

Au total, et avec beaucoup de réserves sur la validité des données, le Comité est en mesure de proposer ce qui suit :

	Marijuana	Haschich
Quantité estimée	800 tonnes	100 tonnes
- dont production nationale	environ 50 %	?
Provenance	Production nationale (Colombie-Britannique, Ontario, Québec) Importations : Mexique, Jamaïque	Importation : Pakistan, Afghanistan, Maroc
Valeur (gros)	2 000 à 4000 $ la livre	?
Valeur détail (once)	225 $ à 250 $	325 $ à 350 $

PROPRIÉTÉS DU CANNABIS

Classifié en pharmacopée comme hallucinogène, psychodysleptique ou psychotomimétique, le cannabis est un perturbateur ou modulateur, c'est-à-dire qu'il modifie les perceptions et les émotions. Classifié dans les conventions internationales ou dans les législations nationales comme stupéfiant, le cannabis fait partie de la classe des psychotropes qui comprend cinq grands groupes : les dépresseurs (alcool, Valium), les stimulants, mineurs (café, nicotine) et majeurs (cocaïne, amphétamines), les perturbateurs (cannabis, LSD), les médicaments contre les psychoses et les médicaments contre les troubles de l'humeur (lithium).

[23] GRC, *État de la situation au Canada – drogues illicites 1999.*

Plus de 460 constituants chimiques connus sont présents dans le cannabis.[24] Parmi eux, plus de 60 sont identifiés sous l'appellation de cannabinoïdes. Le principal ingrédient actif du cannabis, identifié en 1964 par l'équipe du docteur Mechoulam,[25] est le Δ^9-tétrahydrocannabinol communément appelé THC. D'autres cannabinoïdes présents dans le chanvre indien incluent le delta-8-tétrahydrocannabinol, le cannabinol et le cannabidiol mais ils sont présents en faibles quantités et n'exercent pas d'effets significatifs sur le comportement des individus, comparativement au Δ^9-THC[26]. Ils peuvent cependant contribuer à moduler l'effet global du produit[27]. De même, le cannabinol aurait des effets anti-inflammatoires.

Pour mieux saisir les effets du cannabis discutés aux chapitres suivants, il convient de s'arrêter d'abord à ses propriétés pharmacologiques. Ceci étant, le lecteur pourra passer outre cette section technique sans perdre d'information essentielle à la bonne intelligence du reste du rapport. Dans les paragraphes qui suivent, nous discutons d'abord de la teneur en Δ^9THC. Ensuite, nous examinons spécifiquement les propriétés pharmacologiques de ce produit.

Concentration en Δ^9THC

La teneur en Δ^9THC de la marijuana varie généralement dans les conditions naturelles de culture de 0,5 à 4%.[28] La teneur en Δ^9THC sert en premier lieu à distinguer le type drogue du type fibre : la concentration permise varie selon les pays – au Canada, comme en France, elle est de 0,3 % pour le type fibre. Depuis plus d'une décennie, les techniques de sélection de souches puissantes et de culture (en serre ; hydroponique) ont permis d'atteindre des concentrations en Δ^9THC de 15 % et plus. La teneur en Δ^9THC sert aussi à distinguer entre eux divers produits du cannabis et par

---

[24] Voir notamment Grinspoon, L., et J.B. Bakalar (1997) *Marijuana. The forbidden medicine.* New haven and London : Yale University Press; Clark, P.A. (2000) « The ethics of medical marijuana : government restrictions vs. Medical necessity. » *Journal of Public Health Policy*, 21, pages 40-60 ; ainsi que Wheelock (2002) *op. cit.* pour le Comité du Sénat.

[25] Gaoni, Y et R. Mechoulam (1964) « Isolation, structure and partial synthesis of an active constituent of hashish. » *Journal of the American Chemistry Society*, 86, pages 1646-1647 ; et Mechoulam, R. et Y. Gaoni (1965) « A total synthesis of delta-9-tetrahydrocannabinol, the active constituent of hashish. » *Journal of the American Chemistry Society*, 87, pages 3273-3275.

[26] Smith, D.E. (1998) «Review of the American Medical Association Council on Scientific Affairs Report on Medical Marijuana. » *Journal of Psychoactive Drugs.* 30, pages 127-136 ; McKim W.A. (2000) « Cannabis ». in McKim, W.A. (ed.) *Drugs and Behavior. An introduction to behavioral pharmacology.* Upper Saddle River ; prentice Hall.

[27] Ashton, C.H. (2001) «Pharmacology and effects of cannabis : a brief review. » *British Journal of Psychiatry.* 178, pages 101-106.

[28] Huestis, M.A et coll. (1992) «Characterization of the absorption phase of marijuana smoking. » *Clinical Pharmacology and Therapeutics*, 52, pages 31-41.

là leur prix : le sinsemilla par exemple, aura une teneur variant généralement entre 7 % et 14 % et sera plus dispendieux que le cannabis « ordinaire ».

La question de la teneur en Δ^9THC, de sa variabilité, de ses modes de détermination et de ses effets soulève de nombreux débats. Si tous les spécialistes s'entendent pour dire que les concentrations maximales en principe actif ont augmenté au cours des vingt dernières années, les avis sont partagés sur les concentrations moyennes du cannabis disponible sur le marché. La concentration du delta-9-tétrahydrocannabinol fait l'objet d'estimations variables tant en termes de sa prépondérance qu'en termes de ses conséquences.

Il faut d'abord souligner que les études montrent une variabilité extrême des concentrations. On peut citer plusieurs raisons à cet état de fait. Premièrement, à défaut d'un système de contrôle à la source, la teneur en Δ^9THC de la marijuana est estimée à partir des saisies faites par la police. Or, seule une partie des saisies font l'objet d'analyses pour leur teneur en THC,[29] et les analyses ne sont pas toutes aussi fiables entre elles, selon la manière dont les saisies auront été faites par les policiers ou les douaniers et les produits conservés et transportés au laboratoire d'analyse. De plus, entre le produit saisi dans un laboratoire clandestin ou à une entrée douanière et le produit vendu sur la rue, il peut se glisser plusieurs transformations : au gramme de « pot » vendu à l'école, auront été ajoutés du tabac, des herbes, d'autres produits qui en modifient la nature et donc la quantité de principe actif. C'est encore plus vrai pour le haschich, comme on l'a vu plus haut sur l'exemple de la transformation au Maroc.

Deuxièmement, comme il s'agit d'un produit illégal et largement répandu, il est impossible de constituer un échantillon représentatif du cannabis disponible à un moment donné sur le marché pour en faire l'analyse. Il est ainsi impossible de mesurer l'écart entre le contenu en Δ^9THC du cannabis saisi au lieu de production ou de livraison et du cannabis consommé par les particuliers. Et troisièmement, la concentration en produit actif varie selon l'aire géographique de provenance, les conditions climatiques et les conditions de production. Il circule vraisemblablement sur le marché, à un même temps donné, une variété importante de produits du cannabis qui reflètent la diversité des conditions sous lesquelles ils ont été produits. Il s'ensuit que deux échantillons saisis à Vancouver la même semaine pourraient avoir des concentrations très différentes, de même que des échantillons saisis la même semaine à Vancouver, Montréal et St-John's.

Le Comité a entendu des experts lui indiquer que le cannabis sur le marché canadien avait une puissance relative 700 % supérieure à celui des années 1970.

---

[29] Notons par exemple qu'il n'existe aux États-Unis même aucun système systématique de mesure du THC. Comme le souligne une analyse comparative de l'évolution des prix de l'héroïne, de la cocaïne et de la marijuana, « Another problem is that the DEA does not test marijuana for THC content, so there is no marijuana counterpart to the pure grams reported for cocaine and heroin. The difficulty this causes is the STRIDE data provide no basis for adjusting price changes for marijuana's quality. » Abt Associates (2001) *The Price of Illicit Drugs : 1981 through the Second Quarter of 2000.* Washington, DC. Report prepared for the Office on National Drug Control Policy.

Certains ont suggéré que la teneur moyenne en Δ^9THC du cannabis sur le marché serait d'environ 30 %, comparativement aux 3 % à 4 % de celui des années 70.

> *« Le cannabis consommé à l'heure actuelle a une teneur en THC qui oscille entre 5 % et 31 % soit jusqu'à cinq fois plus que le cannabis que la plupart des adultes ont connu dans les années 60 et 70. »*[30]

Dans son rapport annuel pour 1999, la Gendarmerie Royale du Canada indiquait un contenu moyen de 6 % pour les saisies.[31] Au Québec, le Service de police de la Ville de Montréal a affirmé que la teneur en THC du cannabis saisi serait maintenant à 25 %. D'autre part, à l'occasion d'une rencontre privée avec des Membres du Comité, des experts en stupéfiants de la GRC en Colombie-Britannique ont souligné qu'il est *impossible en l'état actuel des choses, de connaître la teneur moyenne du cannabis au pays* ou dans une province donnée, notamment en raison de l'extrême variabilité des saisies et des modes d'analyse. En effet, les agents qui font les saisies ne font pas toujours attention à la façon dont ils conservent le produit, de sorte qu'il peut perdre de sa teneur en Δ^9THC : la chaleur, la lumière, le taux d'humidité, affectent en effet la stabilité du cannabis. Enfin, les experts fournissant le cannabis aux fins thérapeutiques que nous avons rencontrés mentionnent qu'ils conservent des grades différents de cannabis, notamment selon la concentration en Δ^9THC, et que dans certains cas, les produits offerts aux patients atteignent une concentration de 27 %.

Les études les plus exhaustives sur l'évolution de la concentration en Δ^9THC du cannabis ont été réalisées en Australie, aux Pays-Bas, en France et aux États-Unis. On constate d'abord qu'à côté des formes traditionnelles de cannabis sont apparues sur le marché des produits plus puissants : la «skunk» (variété originaire des États-Unis et des Pays-Bas), la « super-skunk » et le « pollen » (étamines des plants mâles). Le Canada n'est pas en reste, avec le *BC Bud* et le *Quebec Gold* notamment.

De manière spécifique, les études sur les concentrations en Δ^9THC révèlent des tendances similaires :

- En Australie, une étude de Wayne et Wendy sur 31 000 saisies effectuées entre 1980 et 1997 constate que le contenu moyen en THC a peu changé sur l'ensemble de la période, se situant dans une fourchette entre 0,6 % et 13 %. Il en ressort que la principale évolution consistait en une sélection plus importante qu'auparavant des parties de la plante les plus fortement

---

[30] Témoignage de Michael J. Boyd, président du Comité sur la toxicomanie et Directeur adjoint du Service de police de Toronto, pour l'Association canadienne des Chefs de police, Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, fascicule no 14, page 74.

[31] Gendarmerie royale du Canada (1999) *Rapport annuel.*

titrées.[32] Les auteurs de cette étude observent ce qui suit et qui, selon nous, s'applique tout aussi bien au Canada ::

[Traduction] *« Pourquoi continue-t-on, en l'absence de données, à croire que la puissance du cannabis a été multipliée par 30 en Australie ? Divers facteurs expliquent selon nous cette croyance. Premièrement, ceux qui avancent cette affirmation se basent souvent sur des rapports provenant d'un échantillon contenant un taux particulièrement élevé de THC testé par la police. Dans le meilleur des cas, un tel échantillon révèle le contenu en THC maximal atteint (à supposer qu'il n'y ait pas d'erreur de mesure) mais il ne nous dit rien du cannabis généralement consommé. Deuxièmement, les biais dans l'échantillonnage du cannabis testé sont amplifiés par les médias qui donnent l'impression que le cannabis à niveau de THC élevé est la norme. Troisièmement, la répétition non contestée de ces affirmations dans les médias finit par les établir comme des « faits », et ceux qui les contestent doivent prouver qu'ils sont faux plutôt que de demander à ceux (le plus souvent anonymes) qui les ont avancés de les démontrer. Et quatrièmement, cette augmentation du contenu moyen en THC expliquerait l'augmentation apparente du nombre d'usagers de cannabis qui ont des problèmes de consommation. »*[33]

- Aux Pays-Bas, le *Drug Information Monitoring System* de l'Institut Trimbos a mené depuis 2000 diverses études sur le contenu moyen en Δ^9THC. La variété locale, le *Nether-Weed* contenait en moyenne 8,6 % de THC en 2000 et 11,3 % en 2001, tandis que les variétés importées étaient stables à environ 5 %. L'une des raisons invoquées pour expliquer cette différence était que la variété locale était plus fraîche et contenait un ratio plus faible de cannabinol par rapport au Δ^9THC. De plus, le *Nether-Weed* ressemble au sinsemilla qui provient des fleurs non fertilisées de la plante femelle et est cultivé sous serre.
- En France, le rapport Roques faisait état de concentrations pouvant atteindre 20 % dans le cas de certaines variétés hydroponiques néerlandaises.[34] De son côté, le récent rapport de l'Institut national de la santé et de la recherche médicale en France rapporte une étude toxicologique menée par Mura sur la concentration en Δ^9THC de saisies depuis 1993. Sur la période 93-95, la moyenne pour l'herbe était de 5,5 % alors que depuis 1996 la moyenne est d'environ 8 % avec des pics pouvant atteindre 22 %.[35] Au cours de l'année 2000, 3 % des échantillons de marijuana analysés contenaient plus de 15 % de Δ^9THC.
- Enfin, aux États-Unis, les données pour 2000 indiquent une concentration moyenne de 6 %, comparativement à 4,1 % en 1997. En

---

[32] Wayne, H. et S. Wendy (2000) « The THC content of cannabis in Australia : evidence and implications." *Australian and New Zealand Journal of Public Health*. 24, pages 503-508.
[33] *Ibid.*, page 504.
[34] Roques, B. (1999) *La dangerosité des drogues*. Paris : Odile Jacob.
[35] INSERM (2001) *Cannabis : quels effets sur le comportement et la santé?* Paris : Les Éditions Inserm.

fait, rappelant une étude menée récemment au Mississipi, le Dr John Morgan a dit ce qui suit :

« (...) malgré tout l'émoi suscité par la forte augmentation de la puissance de la marijuana, on remarquera avec intérêt que la puissance de la variété commerciale vendue aux États-Unis n'a guère varié depuis 30 ans. On l'évalue par l'analyse du contenu en THC dans les stocks saisis par la police. J'ai récemment consulté le rapport qui vient du Mississipi et selon lequel la teneur moyenne en THC des quelque 40 000 saisies effectuées depuis 1974 est d'environ 3,5 %. Elle augmente depuis 10 ans, pour atteindre une moyenne arithmétique de 4 %, je crois, alors qu'au cours de la décennie précédente, la moyenne était d'environ 3,5 %. »[36]

Le tableau suivant résume quelques-unes des données sur une base historique pour certains pays.

Année d'analyse	Marijuana domestique (USA) Marijuana étrangère (Pays-Bas)			Sinsemilla (USA) Nether-Weed (Pays-Bas)		
	= 3 %	= 5 %	= 9 %	= 3 %	= 5 %	= 9 %
USA, 1996[1]	63 %	25 %	3 %	93 %	77 %	49 %
USA, 1997[1]	63 %	29 %	6 %	96 %	85 %	64 %
USA, 2000[2]	Moyenne de 6,07 % (DEA)			Moyenne de 13,65 % (DEA)		
Pays-Bas, 2000-2001[1]	75 %	48 %	7 %	93 %	87 %	35 %
Pays-Bas, 2001-2002[1]	80 %	55 %	4 %	100 %	99 %	78 %
Australie, 1997[3]	Entre 0,6 % et 13 %					
Australie de l'Ouest	Moyenne de 3,8 %					
Canada 1999[4]	Moyenne de 6 %			Non disponible		

(1) Source : Rigter H. et M. von Laar (2002) « Epidemiological Aspects of Cannabis Use» International Scientific Conference on Cannabis, Brussels, p : 32.
(2) Drug Enforcement Administration, http://www.usdoj.gov/dea/concern/marijuana.html
(3) Source : Hall, W. et W. Swift (2000) *op. cit.*, page 505.
(4) Source : GRC, Rapport annuel pour 1999.

En somme, il semble que le principal changement serait dans les concentrations maximales obtenues suite à la sophistication des croisements et des modes de culture, tandis que les concentrations moyennes n'auraient pas changé significativement au cours des trente dernières années[37]. Que faut-il en conclure ? Pour certains, si l'on pouvait encore parler du cannabis comme d'une « drogue douce » dans les années 1970, ce n'est plus le cas aujourd'hui. Certains n'hésitent pas à en faire une drogue comparable à l'héroïne ou à la cocaïne quant à sa puissance addictive. À titre

---

[36] Dr John Morgan, professeur à la City University of New York Medical School, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 11 juin 2001, fascicule no 4, page 29.
[37] ElSohly, M.A., et coll. (2000) « Potency trends of delta9-THC and other cannabinoids in confiscated marijuana from 1980-1997. » *Journal of Forensic Sciences*, 45(1), pages 24-30.

d'exemple, l'Association canadienne des policiers et policières a émis cet avis sur les risques associés au cannabis.

> *« D'une façon générale, la marijuana (cannabis) et ses dérivés sont décrits comme des drogues douces pour les différencier des préjudices connus associés aux autres drogues illicites. Cette approche, en dépit de ses dangers, fonctionne et contribue à l'incompréhension, à la désinformation et à l'accroissement de la tolérance à l'égard de sa consommation. La marijuana est une drogue puissante aux effets variés. (...) La consommation de marijuana est associée à la médiocrité au travail et en classe de même qu'aux problèmes d'apprentissage chez les jeunes. Elle est internationalement reconnue comme drogue d'introduction. Ses facteurs de risque d'assuétude sont comparables à ceux des autres formes de toxicomanie. »*[38]

D'autres, associent l'augmentation de la demande de traitement pour dépendance au cannabis à l'augmentation en concentration de produit actif. Ainsi, cet article du National Post :

> [Traduction] *« La variété puissante de BC Bud, dont le contenu en THC s'élève jusqu'à 25 % comparativement au 2 % des années 1970 génère des inquiétudes pour la santé aux États-Unis. Les admissions pour traitement de dépendances à la marijuana dans l'état de Washington surpassent maintenant celles pour le traitement de l'alcoolisme. En Illinois, pour le seul Cook County, les admissions ont augmenté de 400 % au cours de la dernière année. »*[39]

Peut-on dire que le cannabis est effectivement devenu une drogue «dure » au même titre que la cocaïne et l'héroïne ? Au delà de la validité des effets du cannabis lui-même tels que les décrit l'Association des policiers et dont il sera question en détail au prochain chapitre, pareille affirmation ne tient pas compte des modes d'usage ni non plus de l'absence de connaissance quant aux effets de la concentration en Δ^9THC. Des études sur les modes d'usage dont il sera question au chapitre 6 démontrent en effet que les usagers réguliers semblent préférer un cannabis moyen à doux, et qu'ils ajustent leur consommation à la force. Les entretiens avec des personnes utilisant le cannabis à des fins médicales tendent d'ailleurs à confirmer cette perception. De manière plus importante, on ne sait tout simplement pas quels sont les effets d'une concentration plus élevée en Δ^9THC faute d'études spécifiques sur cette question. Enfin, comme le montrera la section suivante, la bio-disponibilité du Δ^9THC, c'est-à-dire la proportion qui est effectivement absorbée par l'organisme suite à la combustion, est très variable. Comme le souligne le rapport de l'Organisation mondiale de la santé (OMS) sur le cannabis, si l'on tient compte de l'ensemble de ces facteurs, la quantité réelle de THC

---

[38] Sergent Dale Orban, Police de Regina, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 28 mai 2001, fascicule...
[39] National Post, 17 mai 2002.

absorbée par l'usager de cannabis est difficile à estimer.[40] En somme, si la question de la teneur en Δ^9THC doit effectivement nous préoccuper, elle soulève probablement bien plus notre capacité à la contrôler et à en mieux connaître les effets qu'à justifier l'expression de tout et n'importe quoi.

Pharmacocinétique[41]

Après inhalation, et selon la manière de fumer et l'expérience du fumeur, entre 15 % à 50 % du Δ^9THC présent dans la fumée est absorbé et passe dans le flux sanguin. La proportion est dépendante aussi de la concentration en Δ^9THC dans le produit fumé. Cette absorption est très rapide, les concentrations sanguines maximales sont obtenues moins de 15 minutes après le début de l'inhalation. Les effets ressentis presque immédiatement après avoir absorbé la fumée diminuent graduellement au cours des 60 minutes suivantes, et durent généralement un maximum de trois heures après inhalation. Autrement dit, la teneur en THC dans le plasma sanguin est la plus élevée immédiatement suite à l'absorption, tandis que les effets maxima se font ressentir environ 30 à 40 minutes plus tard. Le tableau suivant, reproduit de l'expertise collective de l'INSERM, indique le temps d'apparition et la durée de détection des cannabinoïdes dans le sang.[42]

Concentration, temps d'apparition[1] et durée de détection[2] des cannabinoïdes dans le sang après consommation d'une cigarette de marijuana contenant 15,8 mg ou 33,8 mg de Δ^9THC

Composé	Concentration maximale	Temps d'apparition du pic (h)	Durée de détection (h)
Δ^9THC	84,3 (50-129)[3]	0,14 (0,10-0,17)	7,3 (3-12)
	162,2 (76-267)[4]	0,14 (0,08-0,17)	12,5 (6-27)
11-OH-Δ^9THC	6,7 (3,3-10,4)	0,25 (0,15-0,38)	4,5 (0,54-12)
	7,5 (3,8-16,0)	0,20 (0,15-0,25)	11,2 (2,2-27)
Δ^9THC-COOH	24,5 (15-54)	2,43 (0,8-4,0)	84,0 (48-168)
	54,0 (22-101)	1,35 (0,54-2,21)	152,0 (72-168)

(1) intervalle moyen entre le début de la consommation et l'apparition d'un pic de concentration
(2) intervalle moyen entre le début de la consommation et le moment où la concentration la plus faible du composé est détectée (> 0,5 ng/ml)
(3) cigarette contenant 13,8 mg (1,75 %) de Δ^9THC
(4) cigarette contenant 33,8 mg (3,55 %) de Δ^9THC

---

[40] World Health Organization (1997) *Cannabis : a health perspective and research agenda.* Geneva : WHO, 1997. En ligne à l'adresse : www.who.org

[41] Cette section s'inspire largement du rapport de l'INSERM (2001) *op. cit.*, du rapport de la Conférence scientifique internationale : Pelc, I., (2002) *op. cit.*, et du travail de synthèse réalisé par Wheelock (2002) *op. cit.*, pour le Comité.

[42] INSERM (2001) *op. cit.*, page 340.

La biodisponibilité du Δ^9THC est plus lente et plus faible lorsqu'il est ingéré par voie orale (biscuits, gâteaux, tisanes) : environ 4 % à 12 % ; plus lents à se faire sentir et de qualité différente, ses effets seront cependant plus durables.

Au total, on ne connaît pas l'interaction entre les effets du THC (concentration) et des facteurs personnels (manière de fumer ; condition de santé ; alcoolisme ou prise de médicaments). Il est cependant probable qu'une même concentration en THC n'a pas le même effet sur tous les fumeurs, ce que tendrait d'ailleurs à confirmer la plasticité du cannabis au flux hormonal (voir infra).

Le Δ^9THC est très lipophile et se distribue rapidement dans tous les tissus riches en lipides, dont le cerveau. Il est aussi caractérisé par un cycle entéro-hépatique et une réabsorption rénale qui se traduisent par la persistance de ses effets. Dans une étude sur simulateur de conduite, on a trouvé une corrélation linéaire significative jusqu'à 7 heures suivant l'absorption, notamment sur le suivi de trajectoire.

Le Δ^9THC subit un métabolisme oxydatif conduisant à la production de divers composés, notamment le 11-hydroxy-tétrahydrocannabinol (11-OH Δ^9THC) métabolite psychoactif qui, transporté par l'albumine, tandis que le Δ^9THC est principalement lié aux lipoprotéines, a une pénétration plus importante dans le cerveau que celle du Δ^9THC ; le 8 β-hydroxy-Δ^9-tétrahydrocannabinol, potentiellement psychoactif mais dont la participation serait négligeable ; et divers autres composants non connus pour être psychoactifs. En plus des éléments potentiellement psychoactifs, le cannabis renferme environ 200 produits dérivés de la de combustion et de la pyrolyse, comparables à ceux que l'on trouve dans le tabac mais dont certains à fort pouvoir cancérigène seraient plus concentrés dans la fumée du cannabis que dans celle du tabac.

L'élimination des cannabinoïdes s'effectue par différentes voies : digestive, rénale et sudorale. Environ 15 % à 30 % du Δ^9THC sanguin est éliminé dans les urines, tandis que 30 % à 65 % l'est par les selles. En raison de sa forte fixation tissulaire, le Δ^9THC est éliminé lentement par les urines : chez des gros consommateurs réguliers, des urines présentent des traces de Δ^9THC-COOH 27 jours après arrêt de la consommation.

Les consommateurs réguliers métabolisent le Δ^9THC jusqu'à deux fois plus rapidement que les consommateurs n'ayant jamais consommé auparavant. Une étude a notamment démontré qu'une administration intraveineuse de 5mg de Δ^9THC conduisait à des concentrations sanguines plus élevées chez les consommateurs réguliers que chez les occasionnels.[43]

Les cannabinoïdes agissent sur l'organisme par l'intermédiaire du système cannabinoïde endogène, composé de substances neurochimiques (ligands endogènes) et de récepteurs spécifiques. Les effets comportementaux et centraux du cannabis sont dus aux actions agonistes de ses principes actifs (en particulier le Δ^9THC, cannabinoïde

[43] Cité in INSERM (2001) *op. cit.*, page 148.

exogène) sur les récepteurs des cannabinoïdes endogènes (anandamide, 2-arachidonoylglycérol) présents dans les tissus nerveux du cerveau.

Bien que la structure chimique du Δ^9THC ait été identifiée dès 1964 par Mechoulam[44] ce n'est que tout récemment que l'on a identifié les caractéristiques et la localisation du système cannabinoïde endogène.[45] Deux types de récepteurs cannabinoïdes ont été isolés : CB1 en 1990[46] et CB2 en 1993.[47] CB1 est principalement exprimé dans le système nerveux central et périphérique. CB2 est exprimé essentiellement dans les cellules du système immunitaire. Il suit de cette distribution que CB1 est essentiellement impliqué dans les effets psychotropes et CB2 dans les effets immunomodulateurs.

Les principaux endocannabinoïdes sont l'arachidonoyléthanolamide (aussi appelé anandamide – mot dérivé du sanscrit qui signifie littéralement félicité) et le 2-arachidonoylglycérol (2-AG). Ce sont les deux seules molécules endogènes connues capables de se lier aux récepteurs cannabinoïdes CB1 et CB2 et de mimer les effets pharmacologiques et comportementaux du Δ^9THC. Les niveaux d'anandamide dans le cerveau sont comparables à d'autres neurotransmetteurs tels que la dopamine ou la sérotonine. Les plus hauts niveaux correspondent aux zones de forte expression de CB1, c'est-à-dire l'hippocampe, le striatum, le cervelet ou le cortex. Le 2-AG, tout comme l'anandamide, reproduite tous les effets comportementaux du Δ^9THC ou de l'anandamide mais ses actions sont moins puissantes que celles du Δ^9THC ou de l'anandamide.

Les récepteurs CB1 sont parmi les récepteurs neuronaux les plus abondants du système nerveux central et leur distribution est remarquablement bien correlée aux effets comportementaux des cannabinoïdes sur la mémoire, la perception sensorielle et le contrôle des mouvements, comme le démontre le tableau suivant.

---

[44] Guoli et Mechoulam (1964) *op. cit.*

[45] Devane, W.A. et coll. (1992) «Isolation and structure of a brain constituent that binds to the cannabinoid receptor » *Science*, 258 (5090) pages 1946-1949.

[46] Matsuda, L.A. et coll.. (1990) « Structure of a cannabinoid receptor and functional expression of the cloned DNA » *Nature*, 346(6284) pages 5561-564.

[47] Munro, S. et coll. (1993) «Molecular characterization of a peripheral receptor for cannabinoids. » *Nature*, 365, pages 61-65. Notons qu'une conférence scientifique récente du National Institute on Drug Abuse aux États-Unis rapportait les travaux de chercheurs faisant l'hypothèse qu'il y aurait des récepteurs additionnels et d'autres ligands. Ceux-ci n'ont pas encore, à notre connaissance, été formellement identifiés par la recherche.

Localisation des récepteurs CB1 dans le SNC et effets pharmacologiques corrélés[48]

Structures	Marquage	Conséquences physiologiques	Références
Cerveau antérieur			Herkenham et coll. 1990
Amygdale	+		Herkenham, 1992
Systèmes olfactifs	+		Tsou et coll. 1998, 1999
Cortex cérébral	++	Effets cognitifs	Katona et coll. 1999
Noyaux de la base	++	Effets locomoteurs	Rinaldi-Carmona et coll. 1996
Hippocampe	++	Effets cognitifs (inhibition mémoire à court terme) et action antiépileptique	Matsuda et coll. 1990, 1993 Hohmann, 1999
Thalamus/hypothalamus	+	Effets andocriniens et antinociceptifs	Marsiaco et Lutz, 1999 Westlake et coll. 1994
Cerveau médian	-		
Noyau gris	-		
Collicules	-		
Noyaux optiques	-		
Substances noires/aire tegmentale ventrale			
Cerveau postérieur			
Aire périacqueducale grise	+	Effets antinociceptifs	
Locus coerellus	-		
Raphé	-		
Noyau ponté	-		
Tronc cérébral	-	Pas de dose létale, pas de mortalité aiguë	
Cervelet	++	Effets moteurs (équilibre)	

++ : marquage abondant ; + : marquage intermédiaire ; - : marquage faible ou nul.

Cette concentration des récepteurs CB1 explique largement les effets du Δ^9THC. Ainsi, l'intense expression des récepteurs CB1 dans le noyau de la base et la couche moléculaire du cervelet est en accord avec les effets inhibiteurs des cannabinoïdes sur les performances psychomotrices et la coordination motrice. Leur expression dans le cortex et l'hippocampe est en accord avec la modulation des formes élémentaires d'apprentissage, expliquant notamment les effets délétères réversibles sur la mémoire à court terme et les fonctions cognitives. Leur absence de marquage au niveau du tronc cérébral explique l'absence de toxicité aiguë ou de dose létale des dérivés du cannabis. Les récepteurs CB1 dans le système thalamocortical participent aux perturbations sensorielles et aux propriétés analgésiques du cannabis. De même, la présence de récepteurs dans l'aire périacqueducale et la corne dorsale de la moelle épinière participe à son pouvoir antinociceptif.

Notons aussi que les récepteurs CB1 n'ont pas qu'un rôle inhibiteur des fonctions cérébrales. En raison d'effets de circuit, les cannabinoïdes peuvent provoquer l'excitation de certaines populations neuronales, notamment l'activation des cellules dopaminergiques de la voie mésolimbique. Couplée au constat que le traitement

---

48 Tableau reproduit de INSERM (2001), *op. cit.* page 298.

prolongé au cannabis (à des doses correspondant il est vrai à l'équivalent de 575 cigarettes de cannabis par jour !) semble induire des modifications adaptatives durables du système nerveux central, et à la relation positive entre les cannabinoïdes et les hormones du stress (corticotrophine), cette observation permet d'induire les difficultés (irritabilité, troubles du sommeil, etc.) constatées chez des utilisateurs réguliers lors de la cessation de la prise de cannabis. Nous y reviendrons au chapitre 7 lors de la discussion sur la tolérance et la dépendance au cannabis.

Notons enfin que des travaux récents suggèrent la présence d'importantes variations interindividuelles des effets des cannabinoïdes selon les hormones sexuelles stéroïdiennes chez les mâles et les femelles : il semble que les effets des cannabinoïdes exogènes et endogènes puissent être modulés par l'état hormonal de chaque individu et que, en retour, les récepteurs CB1 et endocannabinoïdes soient capables de réguler l'activité hormonale.

Ainsi que l'avait constaté le rapport de l'OMS en 1997, des questions de recherche demeurent sans réponse, notamment comment et dans quelle mesure l'utilisation de cannabis modifie le système cannabinoïde endogène et quelle est la relation entre les niveaux de cannabinoïdes dans le plasma sanguin et les effets comportementaux induits.

CONCLUSIONS

En conclusion, le Comité retient ce qui suit :

Conclusions du Chapitre 5	
Sur la production	➢ **On estime qu'il circulerait environ 800 tonnes de cannabis au Canada chaque année.** ➢ **La production nationale de cannabis a significativement augmenté et on estime qu'environ 50 % du cannabis circulant au pays est de production endogène.** ➢ **Les principales provinces productrices sont la Colombie-Britannique, l'Ontario et le Québec.** ➢ **Les estimations de la valeur du marché ne sont pas fiables. Ainsi s'il se produit 400 tonnes de cannabis au Canada chaque année, au prix de revente sur la rue à 225 $ l'once, la valeur totale pour le Canada serait de moins de 6 milliards, soit moins que l'estimation policière pour la seule Colombie-Britannique.** ➢ **Une partie inconnue de la production nationale est exportée aux États-Unis.** ➢ **Une partie de la production est contrôlée par des éléments appartenant au milieu du crime organisé.**

Sur le THC	➢ Le THC est le principal composant actif du cannabis ; à l'état naturel, le cannabis contient entre 0,5 et 3% de THC. ➢ Des méthodes de culture sophistiquées et les progrès de la génétique ont permis l'augmentation du contenu en THC au cours des dernières années mais il est impossible d'estimer le contenu moyen du cannabis disponible sur le marché ; il est permis de penser que le contenu des cultures varie entre 6% et 31 %. ➢ Le THC est très liposoluble et se répand rapidement dans les tissus innervés du cerveau ; il atteint un pic dans le plasma sanguin en moins de 9 minutes et il n'en reste qu'environ 5% après une heure. ➢ L'élimination du THC par l'organisme est lente et les métabolites inactifs du THC peuvent être détectés dans les urines jusqu'à 27 jours après consommation dans le cas des usagers réguliers. ➢ Les effets psychoactifs durent en général de 2 à 3 heures après consommation et jusqu'à 5 à 7 heures.

CHAPITRE 6

USAGERS ET USAGES :

FORMES, PRATIQUES, CONTEXTES

Qui sont les usagers de cannabis ? Comment les tendances d'usage au Canada se comparent-elles avec celles d'autres pays ? Dans quels contextes utilise-t-on le cannabis ? Et pourquoi ? Quelles sont les populations les plus vulnérables ? Quelles sont les conséquences sociales du cannabis, notamment sur la délinquance et la criminalité ? Et surtout, quelles sont les trajectoires des usagers de cannabis, notamment eu égard au passage éventuel vers d'autres drogues ?

On peut difficilement établir une politique sur une substance sans répondre au moins partiellement à ces questions. Si l'on veut prévenir, encore faut-il savoir ce que l'on veut prévenir et quels sont les groupes cibles visés. Si l'on veut soutenir ceux qui présentent une consommation à problème, il faut au moins avoir une idée de la composition et de la taille de ce groupe. Plus loin, lorsqu'on voudra des indications qu'une politique publique diminue l'usage ou réduit les usages à risque, on voudra connaître l'évolution des tendances d'usage dans la population.

Or, la situation au Canada eu égard aux connaissances sur les tendances d'usage et les divers contextes d'usage du cannabis est à peu de choses près désastreuse. Alors que les USA, le Royaume-Uni et l'Australie ont mis en place, depuis le début des années 1980, des systèmes d'observation en population générale et en population étudiante menant à des rapports annuels sur les tendances (USA) ou bisannuels (Royaume-Uni et Australie), tandis que plusieurs pays européens se sont dotés, depuis les cinq dernières années, de systèmes de connaissance autour de l'Observatoire européen des drogues et des toxicomanies (OEDT), le Canada n'a mené que deux enquêtes épidémiologiques spécifiques aux drogues en population générale (1989 et 1994) et seules certaines provinces mènent des enquêtes en population étudiante, encore qu'avec des méthodes et des instruments différents réduisant ainsi la comparabilité des données. De surcroît, tout donne à penser qu'il se fait peu d'études sociologiques ou anthropologiques sur les modes et contextes d'usages des drogues illicites, spécifiquement du cannabis. À tout le moins, peu de travaux ont été portés à notre attention. Il s'ensuit que notre bassin de connaissances sur les usagers et les usages est restreint à sa plus petite expression.

Nous n'avons pas d'explications à cette situation. Du moins pas d'explications satisfaisantes. Dès les années 70 le Canada aurait pu, dans les suites des travaux de la Commission Le Dain, se doter d'un système d'observation des tendances. Dans les années 80, dans le contexte de l'adoption de la Stratégie canadienne antidrogues, à laquelle le gouvernement fédéral consacrait 210 millions $ sur cinq ans, un système de collecte d'informations de base aurait pu être créé. Faut-il invoquer l'absence de leadership et de vision ? La peur de connaître ? Les partages de compétences entre les niveaux de gouvernements ? L'absence d'une culture de la recherche socio-légale au sein des ministères responsables de la justice et de la santé ? Probablement un peu de tout et autre chose encore. Quoi qu'il en soit, nous affirmons que cette situation est proprement inacceptable et qu'elle devrait faire l'objet de correctifs rapides et forts. Il nous faudra donc utiliser les maigres données disponibles, ce qui signifie au total bien peu de données. Surtout, peu de données comparables. Nous recourrons aussi à des études et données provenant d'autres pays.

Ce chapitre se divise en quatre sections. La première section porte sur les tendances de consommation, d'abord en population générale, puis spécifiquement chez les jeunes (12 à 18 ans), et compare ensuite les tendances entre divers pays. La deuxième section examine ce que l'on connaît des motifs et modalités d'usage ; il y sera aussi question des origines et différences culturelles entre les usages. La troisième section porte spécifiquement sur les trajectoires des usagers de cannabis, examinant entre autres la question de l'escalade. Enfin, la quatrième section traite des relations entre usage de cannabis et délinquance et criminalité.

TENDANCES D'USAGE

Les enquêtes épidémiologiques sont le principal moyen de mesurer les tendances de la consommation ; elles sont menées en population générale (le plus souvent les 15 ans et plus) et auprès de populations spécifiques, le plus souvent les jeunes en milieu scolaire. La plupart des enquêtes épidémiologiques en population générale procèdent par sondage téléphonique sur la base d'un questionnaire validé. Dans certains cas, elles utilisent l'entretien en face à face. Enfin, certaines enquêtes en milieu scolaire procèdent à partir d'un questionnaire remis aux étudiants en classe.

Parce que la consommation de drogues illicites en population générale est faible, les échantillons doivent nécessairement être grands (au Canada, plus de 12 000 répondants). Quelle que soit la taille de l'échantillon, ces enquêtes sous-estiment inévitablement la consommation : soit parce que les répondants la sous-rapportent, soit en raison de l'interdit légal faisant en sorte que les personnes refusent tout simplement de répondre, soit encore parce que certaines personnes à risque ne seront pas rejointes lors d'une enquête téléphonique. Ajoutons enfin les biais de mémoire : plus il se passe de temps entre la consommation et le moment où est

réalisée l'enquête, moins précis seront les souvenirs relatifs aux moments, circonstances et quantités impliqués.

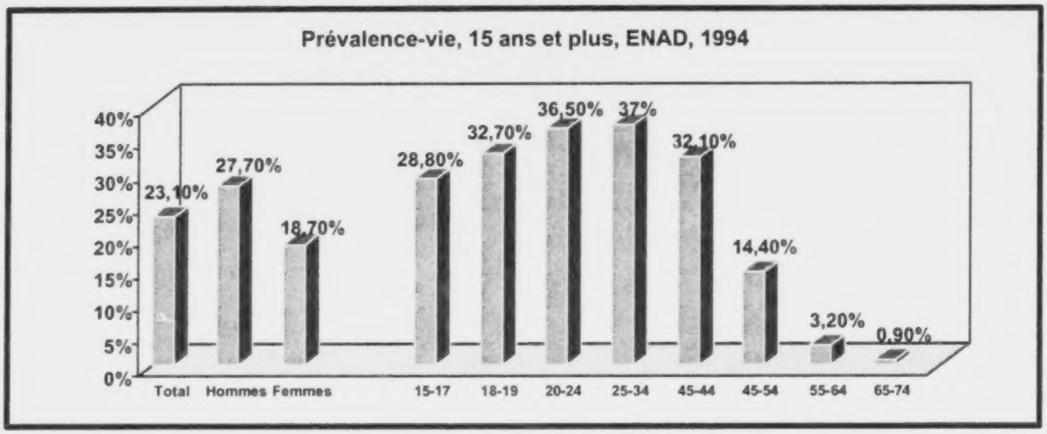
Par ailleurs, notons que certains rapports, dont le rapport de l'INSERM ainsi que le *Profil canadien* du Centre canadien de lutte contre l'alcoolisme et les toxicomanies (CCLAT), rapportent aussi les données des saisies par la police et les douanes au titre d'indicateurs indirects de l'usage. Nous faisons plutôt le choix de rapporter les données sur les saisies et autres activités policières et douanières au chapitre 14. En effet, nous sommes d'avis que ces données reflètent peu et mal les usages et qu'elles sont plutôt des indicateurs de l'activité policière en matière de drogues et pour partie de l'état du marché.

Les enquêtes ne mesurent pas toutes les phénomènes de la même manière, bien que l'on assiste, ces dernières années, à un effort important d'arriver à une plus grande comparabilité. Généralement, on mesure la prévalence-vie, c'est-à-dire le fait d'avoir consommé une substance au moins une fois au cours de sa vie. On distingue cette consommation épisodique ou expérimentale de la consommation au cours de la dernière année. Les mesures de la consommation fréquente, au cours du dernier mois par exemple, sont plus rarement recherchées. Quant aux consommations excessives, elles sont encore moins souvent recherchées. De surcroît, quand il s'agit des consommations régulières, les études ont plutôt tendance à utiliser des critères de dépendance – que nous décrivons en détail au chapitre suivant – plutôt que des indicateurs relatifs aux quantités. Comme on le verra plus en détail plus loin dans ce chapitre, il devient alors difficile de distinguer entre des catégories d'usagers, notamment les usagers à risque et les usagers excessifs. Pourtant, lorsqu'il s'agit d'identifier les groupes cibles pour les actions de prévention notamment, ces informations seraient essentielles.

Consommation en population générale

Au Canada, cinq enquêtes nationales permettent d'avoir des données sur la consommation de substances psychoactives, alcool, tabac et drogues illicites : l'enquête sur la promotion de la santé (EPS) a été menée en 1985 et 1990, l'enquête nationale sur l'alcool et les autres drogues (ENAD) a été menée deux fois, en 1989 et 1994, et l'enquête sociale générale (ESG) de 1993, par ailleurs menée régulièrement, incluait des données sur les drogues. Ce sont ces données que nous présentons dans les paragraphes qui suivent.

Lors de l'enquête de 1994, 23 % des répondants ont déclaré avoir consommé du cannabis au moins une fois dans leur vie. Comme le montre le graphique suivant, les hommes plus que les femmes, les moins de 35 ans plus que les plus âgés, sont nettement plus susceptibles d'avoir consommé du cannabis.



La consommation varie aussi selon les provinces. Ainsi, toujours selon l'enquête ENAD, elle est la plus élevée en Colombie-Britannique (35,4 %) suivie de l'Alberta (29,4 %), du Manitoba (25,2 %), de la Nouvelle-Écosse (25,1 %) et du Québec (24,7 %) et la plus faible à Terre-Neuve & Labrador (16,3 %), en Ontario (16,6 %) et à l'Île-du-Prince-Édouard (18,6 %).

La prévalence-vie était identique à celle de l'étude de 1989. Comparativement, elle était à 3,4 % en 1970 au moment où la Commission Le Dain menait ses travaux et à 17 % en 1978, indiquant une augmentation continue de la consommation de cannabis.

La prévalence au cours des douze derniers mois est un indicateur plus fin de la consommation courante puisque moins sujette aux biais de mémoire. Le tableau suivant décrit l'évolution de cet indicateur depuis l'étude de 1985.

Consommation de cannabis au cours des 12 derniers mois, 15 ans et plus[1]

Année	Enquête	Sexe		
		Hommes	Femmes	Total
1985	Enquête promotion de la santé	6,9 %	4,3 %	5,6 %
1989	Enquête nationale sur l'alcool et les autres drogues	8,9 %	4,1 %	6,5 %
1990	Enquête promotion de la santé	7,0 %	3,0 %	5,0 %
1993	Enquête sociale générale	5,9 %	2,5 %	4,2 %
1994	Enquête nationale sur l'alcool et les autres drogues	10,1 %	5,1 %	7,4 %

[1] Tableau reproduit de CCLAT (1999), *Profil canadien : L'alcool, le tabac et les autres drogues.* Ottawa : auteur, page 142.

Par comparaison, le pourcentage des usagers au cours de la dernière année était de 1 % en 1970 et de 9,7 % en 1979.

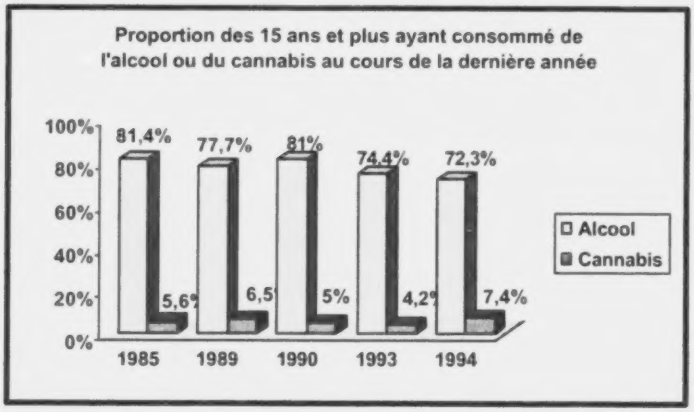
Le taux d'usage rapporté dans ces enquêtes varie du simple au double entre les femmes et les hommes. Surtout, il convient de noter la variabilité entre les études. Parce qu'elle portait spécifiquement sur les substances psychoactives plutôt que de s'insérer dans une enquête plus large sur la santé ou les conditions de vie, l'ENAD nous apparaît plus fiable.

Nous ne disposons pas de données précises sur l'incidence (c'est-à-dire les nouveaux consommateurs) ni sur le taux de discontinuation de l'usage. Sur l'incidence, nous verrons plus loin que l'augmentation de la prévalence chez les jeunes indiquerait une augmentation de l'incidence. Sur la discontinuation, l'on considère généralement que la grande majorité des usagers ne continuent pas au delà d'un usage expérimental, mais nous ne disposons pas de données précises dans la population canadienne.

Nous sommes conscients qu'on ne peut comparer terme à terme les diverses substances psychoactives entre elles. Comme nous le rappelait à juste titre le Dr Zoccolillo lors de son témoignage, chacune a ses caractéristiques et ses effets.

> *« Il est inutile de comparer le niveau des effets nuisibles de la cocaïne, de la marijuana et de l'alcool. Chaque drogue a son genre particulier d'effets nuisibles. S'il fallait comparer les effets du tabac et de la cocaïne chez les jeunes, vous concluriez que la cocaïne est terrible, mais qu'il n'y a pas lieu de s'inquiéter du tabac parce que les effets nuisibles de celui-ci ne se manifestent que 30 ans plus tard. L'essentiel c'est qu'il existe différents genres d'effets nuisibles et qu'il est inutile d'en faire la comparaison. »*[2]

Néanmoins, nous pensons qu'il est utile de comparer la consommation de cannabis au sein de la population générale à celle d'autres substances pour mieux situer le phénomène. L'enquête nationale sur l'alcool et les autres drogues de 1994 montre que, parmi les autres drogues illégales, la consommation de cocaïne est à moins de 1 % et celle d'héroïne, LSD ou amphétamines ensemble à environ 1 %. En ce qui concerne les drogues licites, la consommation d'alcool est à plus de 75 % et celle de tabac à près de



[2] Témoignage du Dr Mark Zoccolillo, professeur de psychiatrie et de pédiatrie, Université McGill et Hôpital pour enfants de Montréal, Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, deuxième session de la trente-sixième législature, 16 octobre 2000, fascicule 1, page 80.

30 %. Le graphique ci-dessus compare la consommation de cannabis à celle de l'alcool chez les personnes de plus de 15 ans.

Des études en population générale sont menées en Ontario depuis 1977. Il s'agit donc de la base de données la plus extensive dont nous disposions au Canada – une base d'autant plus intéressante que l'Ontario mène aussi, depuis 1977, des études en milieu scolaire auprès des jeunes permettant ainsi de mieux suivre les tendances.

Selon le rapport 2000 du Centre sur la toxicomanie et la santé mentale (CTSM)[3], plus du tiers (35 %) des Ontariens de plus de 18 ans ont consommé du cannabis au moins une fois dans leur vie, 10,8 % au cours des 12 derniers mois. Ce pourcentage d'usagers au cours de la dernière année a peu varié depuis 1984 (11,2 %), mais est en légère augmentation par rapport à l'année 1977 (8 %). Le groupe des 18-29 montre l'augmentation la plus régulière, de 18,3 % en 1996 à 28,2 % en 2000 ; par ailleurs, le taux pour ce groupe était à 28,5 % en 1984. Sur le long terme, on observe aussi une augmentation de la consommation au cours des 12 derniers mois chez les 30-49, de 6,2 % en 1977 à 18,7 % en 2000. Le tableau suivant présente certaines données tirées du rapport.

Usagers de cannabis au cours des 12 derniers mois, Ontariens, 18 ans et plus

(N =)	1977 (1059)	1982 (1026)	1984 (1043)	1987 (1075)	1989 (1098)	1991 (1047)	1992 (1058)	1994 (2022)	1996 (2721)	1997 (2776)	1998 (2509)	1999 (2346)	2000 (2406)
Total	8,1	8,2	11,2	9,5	10,5	8,7	6,2	9,0	8,7	9,1	8,6	10,4	10,8
Hommes	11,2	12,3	15,6	12,3	13,0	11,5	9,1	11,4	12,6	11,4	12,1	13,2	14,3
Femmes	4,5	4,1	7,1	6,8	8,2	6,0	3,6	7,0	5,3	7,0	5,4	7,8	7,7
18-29	22,6	22,7	28,5	20	24,6	19,9	13,3	19,6	18,3	21,4	25,2	27,1	28,2
30-39	3,9	4,2	9,5	11,6	11,8	9,1	6,6	10,2	11,3	9,8	8,2	10,3	12,3
40-49	2,3		2,2	5,4	3,9	3,0	2,4	4,3	6,1	4,3	4,6	6,8	6,4
50-64	1,2	1,3	1,8		1,4		1,3			1,7	1,4	4,1	2,9

Parmi ceux qui ont consommé au moins une fois au cours de leur vie, 68 % n'ont pas consommé au cours des derniers 12 mois, 15 % moins d'une fois par mois, et 17 % plus d'une fois par mois ou plus. Parmi les usagers au cours de la dernière année, 47 % consommaient moins d'une fois par mois et 53 % au moins une fois par mois.

Au Québec, des études en population générale ont été menées en 1987, 1992 et 1998. L'enquête sociale et de santé (ESS)[4] de 1998 révèle que 31,3 % des 15 ans et plus ont fait usage du cannabis ou d'une autre drogue illicite au moins une fois dans leur vie et que 13,5 % ont consommé du cannabis au moins une fois au cours des derniers

---

[3] Adlaf, E.M. et A. Ialomiteanu (2000) *CAMH Monitor Report : Addiction and Mental Health Indicators among Ontario Adults, 1977-2000.* Toronto : Centre for Addiction and Mental Health, pages 61-67.

[4] Chevalier, S. et O. Lemoine (2000) « Consommation de drogues et autres substances psychoactives » dans *Enquête sociale et de santé 1998*, Québec : Institut de la statistique du Québec, chapitre 5, page 137.

mois. Comme ailleurs, la consommation est fonction de l'âge : chez les 15-24, la consommation de drogues illicites est de 39,7 %, elle est de 18,4 % chez les 25-44, de 8 % chez les 45-64, et de 5,5 % chez les 65 ans et plus. Si 83,7 % des 45-64 ans et 93,8 % des 65 ans et plus disent ne jamais avoir fait usage de drogues prohibées, plus de 40 % des 25-44 ans et la moitié (50,3 %) des 15-24 ans affirment en consommer ou l'avoir déjà fait.

Consommation chez les jeunes

Plusieurs témoins ont fait état d'augmentations « préoccupantes » de la consommation de cannabis chez les jeunes de moins de 18 ans.

> *« Grâce aux études qui indiquent que le taux de consommation du cannabis chez les jeunes en général, et plus particulièrement chez les jeunes de la rue et les jeunes à risque, et aux connaissances sur les méfaits de la consommation de drogues, nous savons que le problème devient de plus en plus aigu. »*[5]

> *« Il faut porter une attention spéciale aux mineurs quand on élabore une politique en matière de drogues. Une politique visant uniquement les adultes aura peut-être de vives conséquences non voulues sur les adolescents. Nous avons une obligation parentale à l'égard des adolescents. Ce ne sont pas des adultes. »*[6]

> *« Le sondage réalisé auprès des élèves ontariens est également déroutant. On constate une forte hausse de l'usage des drogues, quelles qu'elles soient, depuis 1993. (...) Celle du cannabis a plus que doublé et atteint 29 %. (...) Malheureusement, les seules statistiques qui sont en régression sont celles qui concernent les élèves qui ne consomment pas de drogues. Le chiffre est tombé de 36 à 27 %, et l'on est donc passé de près d'un tiers à près d'un quart aujourd'hui. Nous sommes manifestement à une époque où les jeunes voient dans les drogues une solution à leurs problèmes existentiels. »*[7]

De fait, la consommation de substances psychoactives chez les jeunes en milieu scolaire a connu des augmentations significatives au cours des dernières années. Au plan national, l'enquête réalisée auprès des jeunes de 6^e^, 8^e^ et 10^e^ années (environ 2 000 jeunes par niveau scolaire) en 1990, 1994 et 1998[8], rapporte que l'utilisation de la marijuana a évolué de la manière suivante :

---

[5] Témoignage de M.J. Boyd, président du Comité sur la toxicomanie et sous-chef du Service de police de Toronto, Association canadienne des chefs de police, Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 11 mars 2002, fascicule 14, page 77.

[6] Témoignage du Dr Mark Zoccolillo, *op. cit.*, page 79.

[7] Témoignage de R.G. Lesser, surintendant principal, Gendarmerie Royale du Canada, Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 29 octobre 2001, fascicule 8, page 9.

[8] King, A.J.C. et coll., (1999) *La santé des jeunes : tendances au Canada. Les comportements de santé des jeunes d'âge scolaire.* Ottawa : Santé Canada.

Étudiants de 8e et 10e année qui ont consommé du cannabis au moins une fois

	1990	1994	1998
8e année			
filles	10 %	11 %	18 %
garçons	11 %	13 %	21 %
10e année			
filles	24 %	27 %	41 %
garçons	26 %	30 %	44 %

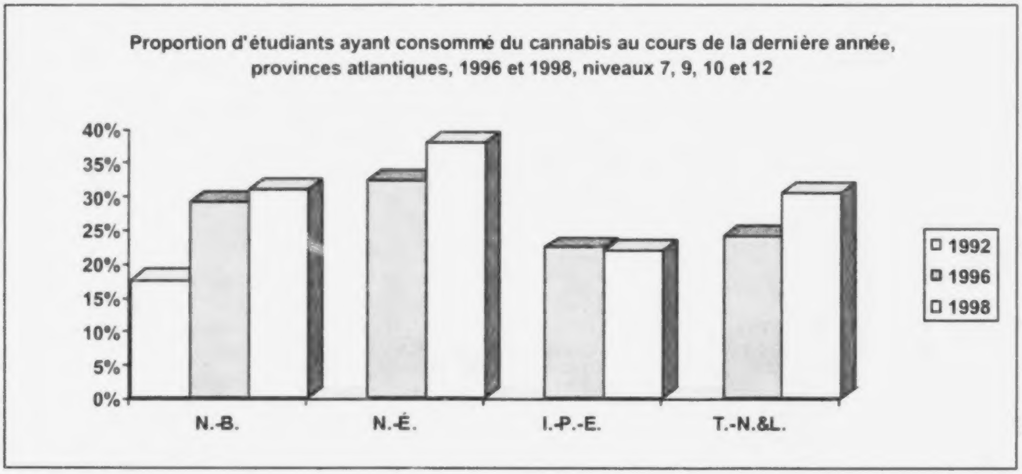
Des enquêtes sur la consommation de substances psychoactives, dont le cannabis, chez les jeunes, ont été menées dans certaines provinces. Elles permettent d'avoir une image plus précise de l'évolution de la consommation de cannabis chez les jeunes dans ces provinces, mais leurs résultats ne sont cependant pas comparables d'une province à l'autre.

Atlantique

Dans les provinces atlantiques (Terre-Neuve & Labrador, Île-du-Prince-Édouard, Nouvelle-Écosse et Nouveau-Brunswick) la consommation de cannabis chez les jeunes de niveau secondaire a fait l'objet d'enquêtes universelles identiques pour la première fois en 1996.[9] L'étude s'est répliquée en 1998. L'enquête de 1996 a porté sur 14 908 étudiants et celle de 1998 sur 13 539 étudiants des niveaux 7, 9, 10 et 12.[10]

Le graphique suivant présente les principales données des deux enquêtes et la base de 1992 pour le Nouveau Brunswick.

La consommation de cannabis chez les étudiants dans les provinces atlantiques



[9] Le Nouveau Brunswick a mené des études en population scolaire en 1986, 1989 et 1992.

est passée de 28 % en 1996 à près de 33 % en 1998. Par province, observe les tendances suivantes :

❖ *En Nouvelle-Écosse, entre 1991 et 1998 :*

- Le pourcentage d'étudiants utilisant des drogues illicites a presque doublé ;
- Le pourcentage d'étudiants déclarant avoir consommé du cannabis au cours de la dernière année est à près de 38 % en 1998, comparativement à 32 % en 1996 ;
- La répartition par niveau est la suivante : 11,4 % au niveau 7, 41 % au niveau 9, 47,6 % au niveau 10 et 51,7 % au niveau 12 ;
- Le pourcentage d'étudiants utilisant du cannabis plus d'une fois par mois a triplé, passant de 4,4 % à 13,5 % ; les hommes (17,5 %) sont plus nombreux que les femmes (9,3 %) à consommer une fois par mois.

❖ *Au Nouveau Brunswick :*

- La proportion d'étudiants déclarant avoir consommé du cannabis est passée de 17,4 % en 1992 à 29 % en 1996 et à 31 % en 1998 ;
- Parmi les usagers de cannabis, 5,5 % ont expérimenté au cours de l'année et 11 % étaient des usagers fréquents (plus d'une fois par mois) ;
- Comme dans les autres provinces, les hommes (33,4 %) sont plus nombreux que les femmes (28,3 %) à consommer du cannabis ;

En comparaison, 56 % des étudiants des provinces atlantiques en 1996 et près de 59 % en 1998 ont déclaré avoir consommé de l'alcool au moins une fois au cours de l'année précédente.

Manitoba

Au Manitoba, une enquête non aléatoire d'écoles de la province a été menée en 2001 auprès de 4 680 étudiants provenant de 32 écoles.[11] Même si l'échantillon n'est pas totalement représentatif de l'ensemble des étudiants du Manitoba, il est suffisamment important pour offrir une bonne représentation de la situation dans la province.

La quasi-totalité des étudiants ayant déclaré avoir consommé des drogues illicites au cours de l'année précédente ont utilisé de la marijuana (96 %) : 47,7 % des étudiants ont consommé au moins une fois dans leur vie et 39,7 % au cours de l'année

---

[10] Voir http://www.gov.ns.ca/health/student-drug-use/contents.htm pour la Nouvelle-Écosse et http://www.gnb.ca/0378/en/sdus1998/index.htm pour le Nouveau-Brunswick. Un sommaire est aussi disponible sur le site du CCLAT à l'adresse http://www.ccsa.ca/Reports/STUDENT.HTM

[11] Patton, D., et coll., (2001) *Substance use among Manitoba high school students.* Winnipeg : Addictions Foundation of Manitoba. Disponible sur le site www.afm.mb.ca

précédente (comparativement à 37,4 % en 1995 et à 38,8 % en 1997). L'âge moyen à la première utilisation est de 14,1 ans. Les garçons (40,4 %) sont plus nombreux que les filles (35,4 %) à avoir consommé du cannabis au cours de l'année précédente. Parmi les usagers, 8,5 % consommaient à peu près une fois par mois et 15,8 % plus d'une fois par mois (20,5 % chez les garçons et 11,2 % chez les filles).

Par comparaison, 87,4 % des étudiants ont consommé de l'alcool au moins une fois dans leur vie et 80,4 % au moins une fois au cours de l'année précédente. L'âge moyen de la première consommation est de 13,3 ans. Parmi ceux qui ont consommé au cours de l'année précédente, 26 % l'ont fait une fois par semaine ou plus, et 46,5 % au moins une fois par mois. On observe une progression de la consommation hebdomadaire par niveau, de 17 % au niveau 1 à 33 % au niveau 4. Notons enfin que 27,7 % des étudiants ont consommé cannabis, alcool et tabac au cours de la dernière année.

Ontario

En Ontario, l'enquête sur la consommation des drogues parmi les étudiants[12] (OSDUS) 2001 révèle qu'en moyenne 33,6 % des jeunes entre la 7e et la 13e année rapportent avoir consommé du cannabis au moins une fois et 29,8 % au cours des derniers mois (les pourcentages sont de 33,8 % et 23,6 % pour le tabac et 70,6 % et 65,6 % pour l'alcool). Le taux d'utilisation est significativement plus élevé pour les garçons que chez les filles. Si l'on examine l'évolution des tendances, on constate qu'après avoir atteint un creux au début des années 90, les taux des deux dernières enquêtes sont comparables à ceux de la fin des années 70 et du début des années 80.

Usagers de cannabis au cours des 12 derniers mois, Ontariens, 7e à 13e année

(N =)	1977 (4687)	1979 (4794)	1981 (3270)	1983 (4737)	1985 (4154)	1987 (4267)	1989 (3915)	1991 (3945)	1993 (3571)	1995 (3870)	1997 (3990)	1999 (2868)	2001 (2326)
Total	25,1	31,7	29,9	23,7	21,2	15,9	14,1	11,7	12,7	22,7	24,9	29,2	28,6
Hommes	29,4	36,4	33,2	28,0	24,4	18,7	14,7	13,2	14,8	25,7	25,7	32,5	32,1
Femmes	21,1	26,8	26,3	19,4	17,9	13,2	13,5	9,9	10,7	19,8	24,1	25,8	25,1
7e	5,6	10,4	5,7	5,2	4,7	3,8	0,9	0,7	1,7	2,8	3,4	3,6	5,1
8	-												
9e	23,2	29,2	27,1	25,1	18,3	12,1	12,9	8,1	8,7	19,6	23,9	25,5	28,8
10e	-												
11e	39,4	50,2	44,2	42,1	35,1	24,3	22,5	20,2	22,3	40,7	42,0	48,1	45,7
12e	-												
13e	42,4	43,6	37,4	36,5	30,8	30,5	28	20,5	21,6	27,5	31,9	43,3	43,9

[12] Adlaf, E.M. et A. Paglia (2001) *Drug Use among Ontario Students 1977-2001. Findings from the OSDUS.* Toronto : Centre for Addiction and Mental Health.

Lorsqu'on compare les tendances d'usage du cannabis à celles d'autres substances, on observe que :

- La consommation de tabac au cours des 12 derniers mois a diminué de 30,4 % à 22,3 % des élèves ;
- La consommation d'alcool au cours des 12 derniers mois a diminué de 76,3 % à 62,6 % des élèves ;
- La consommation d'héroïne est passée de 2,0 % à 1,2 % ;
- La consommation de cocaïne est demeurée stable à 3,8 % ;
- La consommation d'amphétamines est passée de 2,7 % à 3,1 % ;
- La consommation d'ecstasy est passée de 0,6 % en 1993 (première mesure) à 6,0 % en 2001.

L'enquête ontarienne examine la fréquence de la consommation. Parmi les usagers de cannabis en 2001, 25 % en ont consommé une ou deux fois, 30 % entre 3 et 9 fois, et 45 % plus de 10 fois. Au total, 16,9 % de tous les étudiants ont consommé du cannabis au moins 6 fois au cours des 12 derniers mois. Le tableau suivant décrit l'évolution de la fréquence de consommation au cours des 12 derniers mois depuis 1981.

Fréquence de consommation au cours des 12 derniers mois parmi les usagers, Ontario[13]

	1981 (1002)	1983 (1304)	1985 (907)	1987 (701)	1989 (570)	1991 (515)	1993 (455)	1995 (873)	1997 (1019)	1999 (778)	2001 (636)
1-2 fois	28,2	32,4	33,7	39,8	42,6	37,1	41,1	31,7	29,5	28,8	25,6
3-5	12,4	15,1	18,3	16,2	17,2	17,7	17,5	17,1	16,3	14,7	17,1
6-9	14,0	12,5	11,3	9,0	10,5	12,2	10,1	10,4	12,4	13,9	11,4
10-19	13,0	11,4	11,3	14,1	11,8	9,8	9,0	12,5	12,3	11,9	14,9
20-39	10,7	9,0	8,3	6,2	8,3	8,9	8,8	9,0	9,8	9,5	10,2
40 +	21,7	19,5	17,1	14,8	17,1	14,3	13,6	19,4	19,7	21,2	20,9

De manière encore plus pointue, l'étude examine la consommation au cours des quatre dernières semaines. Au total, 8,4 % des étudiants ont consommé du cannabis sur une base hebdomadaire et 3,1 % sur une base quotidienne. La proportion des étudiants qui n'ont pas consommé de cannabis au cours du dernier mois est passée de 90,2 % en 1987 à 66,6 % en 2001.

Le tableau suivant décrit l'évolution de la consommation mensuelle parmi les usagers des douze derniers mois au cours de la période 1987-2001. On y observe notamment une diminution de ceux qui n'ont pas fait usage du cannabis au cours du

[13] Tableau reproduit de Adlaf et Paglia, *op. cit.*, page 57.

dernier mois (de 41 % en 1987 à 30 % en 2001) et, inversement, une augmentation de ceux qui ont en ont fait un usage quotidien (de 3,5 % en 1987 à 9,1 % en 2001).

Fréquence de l'usage mensuel parmi les usagers des douze derniers mois, osdus[14]

—	1987 (701)	1989 (570)	1991 (515)	1993 (455)	1995 (873)	1997 (1019)	1999 (778)	2001 (636)
Jamais								
Total	41,1	46,0	44,1	37,2	30,9	33,0	30,5	30,6
Hommes	38,1	44,8	38,6	29,7	28,4	28,9	28,5	23,2
Femmes	45,3	47,2	51,8	47,5	33,8	36,9	33,0	39,8
1-2 fois le mois								
Total	36,6	38,3	34,5	36,9	35,7	34,2	34,8	33,2
Hommes	36,7	33,8	33,4	35,8	33,8	30,4	31,1	32,9
Femmes	36,4	42,9	36,0	38,1	37,9	37,9	39,4	33,6
1-2 fois la semaine								
Total	9,7	9,6	7,9	9,9	14,4	13,7	12,5	11,3
Hommes	9,8	10,6	8,7	12,7	15,5	14,6	12,9	12,3
Femmes	9,5	8,5	6,7	6,1	13,2	12,8	12,0	10,1
3-4 fois la semaine								
Total	4,9	2,6	5,8	5,9	9,2	7,6	8,5	8,3
Hommes	4,6	4,8	8,5	7,4	9,4	10,2	10,2	9,9
Femmes	5,5	0,4	2,0	3,8	9,0	5,1	6,3	6,4
5-6 fois la semaine								
Total	4,1	1,0	2,4	5,1	3,6	3,9	4,4	7,4
Hommes	5,3	1,9	3,2	7,5	4,4	4,5	5,9	7,5
Femmes	2,5		1,2	2,0	2,5	3,4	2,6	7,3
Chaque jour								
Total	3,5	2,6	2,6	5,0	6,3	7,6	9,3	9,1
Hommes	5,6	4,1	4,1	6,9	8,6	11,4	11,3	14,3
Femmes	0,8	1,1	1,1	2,4	3,6	3,9	6,6	2,8

L'enquête OSDUS permet aussi de savoir quelle quantité est consommée. Parmi les usagers des 12 derniers mois en 2001, 15 % ont fumé moins d'un joint, 21 % environ un, 22 % en ont fumé 2 à 3, et 15 % plus de 4. Enfin, l'étude examine aussi la question de l'âge de la première initiation. Au total, en 2001, 10,2 % des étudiants ont utilisé du cannabis pour la première fois, dont 31,7 % des usagers de cannabis au cours des 12 derniers mois. L'âge d'initiation ne varie pas selon le sexe ou la région mais est significativement relié au niveau scolaire : entre la huitième et la neuvième année (14-15 ans), la proportion de ceux qui ont fumé du cannabis passe de 6% à 14,9 %.

[14] *Ibid.*, page 58.

L'initiation précoce (7[e] année, environ 12 ans) au cannabis a diminué au fil des ans : en 2001, 2% des étudiants de 7[e] disaient avoir utilisé du cannabis au moins une fois l'année précédente (soit vers l'âge de 11 ans), un taux inférieur à celui qui était enregistré en 1997 (5 %) et en 1981 (8 %).

Québec

Au Québec, on constate selon certains observateurs une augmentation « inquiétante » de la consommation régulière de cannabis chez les jeunes. Selon Michel Germain, directeur du CPLT, l'augmentation de l'usage serait davantage reliée à des valeurs sociales, notamment à des messages relatifs à une certaine banalisation de l'acceptabilité des drogues, qu'à des facteurs sociodémographiques tels le revenu ou la composition familiale.

Les données disponibles ne sont pas immédiatement comparables à celles qui sont recueillies en Ontario. Elles proviennent des trois enquêtes menées par Santé Québec en 1987, 1992 et 1998 en population générale et portent sur le groupe des 15-24 ans : respectivement 3 136, 3 912 et 3 587 répondants), distingué entre les 15-17, les 18-19 et les 20-24.[15]

L'étude révèle d'abord une diminution statistiquement significative du nombre de jeunes qui déclarent n'avoir jamais consommé de drogues entre 1987 et 1998 (71,3 % en 1987, 57,4 % en 1992 et 50,3 % en 1998). Les consommateurs « actuels », au cours des douze derniers mois, sont 39,7 % des jeunes en 1998 contre 27 % en 1992. Par tranche d'âge, l'augmentation de la consommation de drogues illicites (significative dans chaque cas à $p < .001$) se traduit ainsi :

- 15 – 17 ans : 26,2 % à 37,6 %
- 18 – 19 ans : 28,1 % à 41,6 %
- 20 – 24 ans : 26,2 % à 40,3 %

Parmi les usagers de drogues, le pourcentage de ceux qui utilisent de la marijuana exclusivement est passé de 15 % en 1992 à près de 26 % en 1998, tandis que la proportion de ceux qui utilisent d'autres drogues est demeurée stable à environ 13 %.

Tendances d'usage dans d'autres pays

Les tendances d'usage ne sont évidemment pas comparables immédiatement d'un pays à l'autre, non seulement en raison de différences culturelles, mais aussi parce que les systèmes de collecte sur les tendances d'usage ne mesurent pas tous la même chose de la même manière, ni souvent sur les mêmes années. En Europe, les travaux de

---

[15] Vitaro, F, Gosselin C. et A. Girard (2002) *Évolution de la consommation d'alcool et de drogues chez les jeunes au Québec de 1987 à 1998 : constatations, comparaisons et pistes d'explication.* Montréal : Comité permanent de lutte à la toxicomanie.

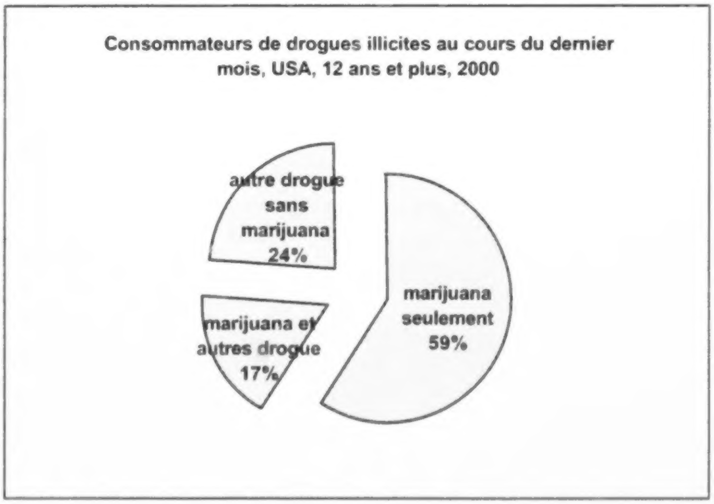
l'Observatoire européen sur les drogues et les toxicomanies (OEDT) permettent peu à peu d'arriver à une uniformisation des collectes de données dans les divers pays de l'Union permettant ainsi une meilleure comparabilité. Néanmoins, il subsiste des différences importantes entre les pays.

Malgré ces réserves, il est intéressant de comparer les tendances d'usage entre les divers pays. Dans un premier temps, nous examinons la situation aux États-Unis, au Royaume-Uni, en France et aux Pays-Bas et dans un deuxième temps nous tentons des comparaisons sur quelques indicateurs sélectionnés.

États-Unis

Aux États-Unis, deux grandes enquêtes sont menées depuis plusieurs années : une enquête en population générale sous l'égide du ministère de la Santé et l'étude *Monitoring the Future* de l'Université du Michigan pour le compte du *National Institute on Drug Abuse* (NIDA) auprès de cohortes de gradués.

L'enquête en population générale pour 2000[16] révèle que 6,3 % des Américains de 12 ans et plus ont fait usage de drogues illicites au cours du dernier mois, et 4,8 % (contre 4,7 % en 1999) ont consommé du cannabis. Au total, 14 millions d'Américains sont considérés comme *usagers actuels* de drogues illicites, c'est-à-dire ceux qui ont consommé au cours du dernier mois. Le graphique ci-contre montre que, parmi ce groupe d'usagers, 76 % sont consommateurs de marijuana et 59 % de marijuana seulement.

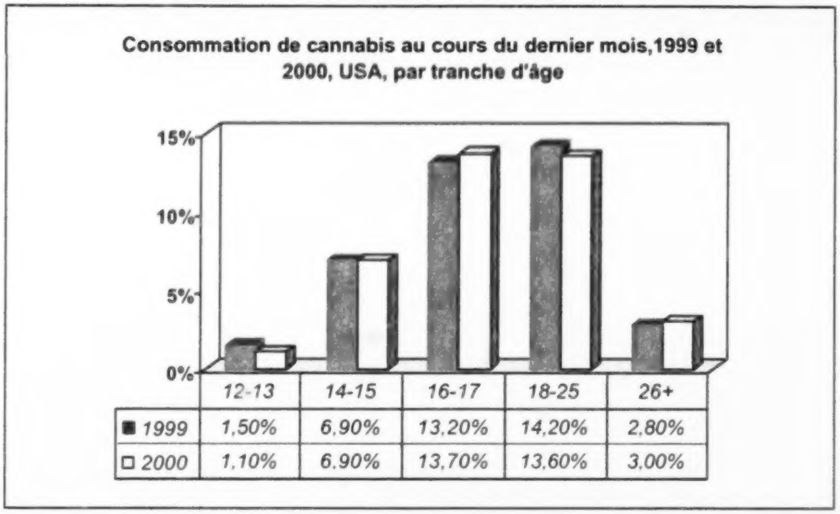


On estime que le nombre des nouveaux usagers en 1999 était de 2 millions, contre 2,6 millions en 1996 et 1,4 millions en 1990. Les deux tiers des nouveaux consommateurs ont entre 12 et 17 ans, les autres entre 18-25. L'âge moyen de la première expérimentation de cannabis est de 17 ans en 1999, comparativement à environ 19-20 à la fin des années 1960.

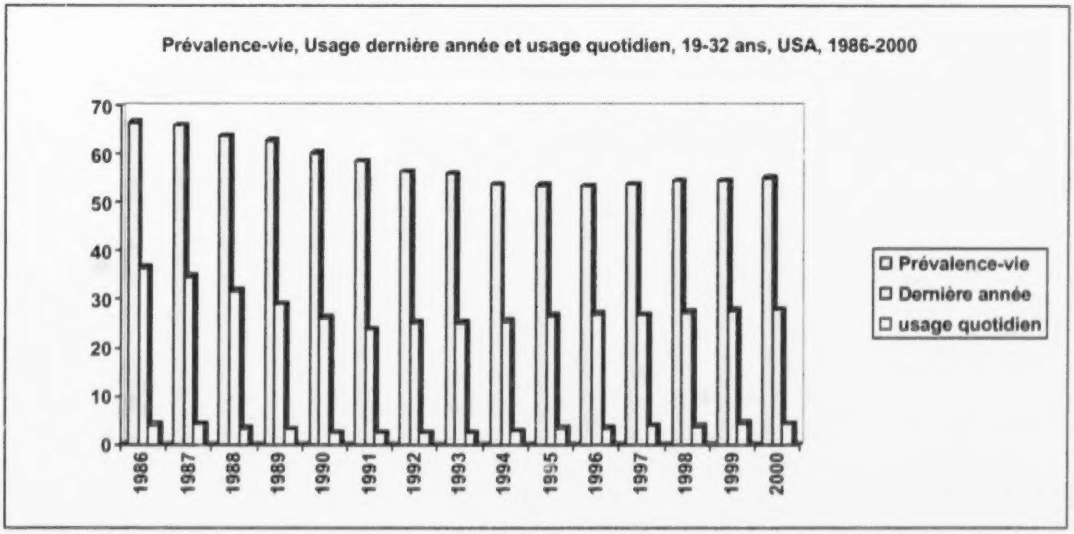
La fréquence de consommation chez les usagers courants aurait augmenté entre 1999 et 2000 : 31,6 % en 1999 ont consommé du cannabis 100 jours ou plus au cours

[16] Substance Abuse and Mental Health Services Administration (2001) *Summary of findings from the 2000 national household survey on drug abuse.* Washington, DC : Department of Health and Social Services

de l'année précédente, comparativement à 34,7 % en 2000. Enfin, la répartition des groupes d'âge suit les tendances attendues comme le montre le graphique suivant :



L'enquête *Monitoring the Future* 2000[17] présente les tendances d'usage depuis 1986 pour des cohortes de jeunes gradués compris entre 19 et 32 ans. La figure suivante résume ces données.



[17] Johnston, L.D., et coll., (2001) *Monitoring the future. National Survey Results of Drug Use, 1975-2000. Volume II College Students and Young Adults Ages 19-40.* Bethseda, Michigan : NIDA.

En 2000, la prévalence-vie chez les personnes de 31-32 ans atteignait 73 % pour l'ensemble des drogues illicites, et 68 % pour la marijuana.

Royaume-Uni

Au Royaume-Uni, le *British Crime Survey*[18] mesure les tendances d'usage de drogues illicites depuis le début des années 1980 à chaque deux ans. Depuis la création de l'OEDT, l'organisme *Drugscope*[19] est devenu le correspondant pour le Royaume-Uni et fait état annuellement des tendances d'usage et d'indicateurs connexes.

Le pourcentage de répondants âgés entre 16 et 59 ans ayant consommé une drogue illicite *au cours de l'année précédente* au Royaume-Uni est passé de 9,9 % en 1994 à 10,7 % en 2000. Pour le cannabis, les proportions sont 8,4 % et 9,4 % respectivement. La *prévalence-vie* de l'usage de cannabis chez les 16-29 ans est passée de 34 % en 1994 à 44 % en 2000. En fonction du groupe d'âge, les tendances d'usage au cours de la dernière année sont les suivantes :

- Chez les 16-19 ans : de 29 % en 1994 à 25 % en 2000 ;
- Chez les 20-24 ans : de 23 % en 1994 à 27 % en 2000 ;
- Chez les 25-29 ans : de 12 % en 1994 à 17 % en 2000.

Dans chaque cas, les hommes consomment plus que les femmes.

Le rapport note que le changement le plus important concerne la consommation de cocaïne chez les jeunes hommes de la classe d'âge des 16-29 ans dont la consommation est passée de 1,2 % à 4, 9 %.

France

Les travaux de l'Observatoire français des drogues et des toxicomanies (OFDT) ont permis une sérieuse mise à niveau de la connaissance des tendances et de la veille en France. L'OFDT publie un rapport bisannuel sur les tendances d'usage et les indicateurs connexes (saisies, interpellations, demandes de traitement, etc.) ainsi qu'une série d'études et de rapports techniques sur des enjeux spécifiques. Dans son rapport 2002, l'OFDT[20] montre que la consommation de cannabis se répartit comme suit :

- Prévalence-vie : 21,6 % de la population adulte (18-75)
- Usage occasionnel (au moins une fois dans l'année) : 6,5 %
- L'usage répété (au moins dix fois dans l'année) : 3,6 %
- L'usage régulier (dix fois par mois et plus) : 1,4 %.

---

[18] Les rapports pour 1998 et 2000 sont disponibles en ligne sur le site web du Home Office à l'adresse : http://www.homeoffice.gov.uk/rds/pdfs/hors224.pdf

[19] Le rapport 2000 est disponible en ligne à l'adresse : http://www.drugscope.org.uk/wip/11/3/pdf/UK%20DRUG%20SITUATION%202001.pdf

[20] Observatoire français des drogues et des toxicomanies (2002) *Drogues et dépendances. Indicateurs et tendances 2002.* Paris : auteur, pages 98-99.

Il y a près de deux fois plus d'expérimentateurs chez les hommes que chez les femmes et parmi les 18-34 ans 40,5 % sont expérimentateurs. La proportion d'expérimentateurs décroît avec l'âge. La consommation répétée concerne 14,6 % des 18-25 et 1,6 % des personnes de plus de 26 ans. L'OFDT note que «*la part de la population adulte (âgée de 18-44 ans) ayant expérimenté le cannabis est de plus en plus élevée. Cette augmentation est la marque d'une banalisation du cannabis.* » D'autant plus que chez les adolescents la consommation a progressé significativement. Ainsi, en 1993, 34 % des garçons et 17 % des filles déclaraient avoir consommé du cannabis à 18 ans, contre 59 % et 43 % respectivement en 1999. En fait, ajoute le rapport de l'OFDT, « *l'expérimentation du cannabis est devenue un comportement majoritaire chez les jeunes arrivant à l'âge adulte* ».

De manière intéressante, le rapport de l'OFDT permet de construire une typologie des usages, voire si l'on étend un peu le raisonnement de proposer des balises pour les comportements qui peuvent présenter des risques.

Le tableau suivant présente la fréquence de consommation chez les jeunes à la fin de l'adolescence.[21] Au delà du clivage de sexe déjà noté dans les autres enquêtes épidémiologiques, on y observe que moins du quart des garçons de 17 ans déclarent fumer de façon au moins répétée alors qu'ils sont le tiers à 19 ans. De même, entre 17 et 19 ans, chez les garçons, la part des abstinents baisse de 10 points.

Fréquence de la consommation de cannabis chez les jeunes à la fin de l'adolescence en 2000, par âge, sexe et type de consommation

Type de consommation	Définition	Filles, 17 ans	Garçons, 17 ans	Garçons, 18 ans	Garçons, 19 ans
Abstinent	Jamais	59,2	49,9	45,1	39,8
Expérimentateur	Déjà consommé mais pas au cours de l'année	5,0	5,4	6,5	8,2
Occasionnel	Entre 1 et 9 fois par an	23,3	20,9	19,9	19,4
Répété	Plus de 9 fois par an moins de 10 fois par mois	7,4	9,3	9,9	10,1
Régulier	Entre 10 et 19 fois par mois	2,6	6,4	6,2	6,8
Intensif	20 fois et plus par mois	2,6	8,0	12,4	15,8

L'autre découpage intéressant proposé dans le rapport de l'OFDT – découpage qui peut mettre sur la piste de situations problématiques (et qui pourrait notamment être utile aux fins de prévention) même si le rapport prend soin de préciser qu'il n'y a pas recoupage entre ces profils et les risques – porte sur les modes de consommation.

[21] *Ibid.*, page 100.

Il s'agit ici du fait de fumer seul et le matin ou le midi. On observe une relation linéaire presque parfaite entre les types et les modes de consommation comme l'indique le tableau suivant.[22]

Fréquence de l'usage de cannabis le matin ou en solitaire chez les jeunes à la fin de l'adolescence en 2000 par type de consommation

Type de consommation	Matin ou midi			Seul		
	Jamais	Parfois	Souvent	Jamais	Parfois	Souvent
Occasionnel	57,2	40,4	2,4	81,9	16,2	1,9
Répété	17,9	69,8	12,3	46,4	46,6	7,0
Régulier	4,7	58,9	36,4	19,9	60,2	19,8
Intensif	1,1	22,7	76,1	4,5	38,2	57,3

C'est là ce qu'expliquait le Directeur de l'Observatoire, monsieur Jean-Michel Coste, lors de son témoignage devant le Comité :

> *« Je crois qu'il est extrêmement important de répondre aux préoccupations des pouvoirs publics lorsqu'en matière de prévention, ces pouvoirs publics sont à la recherche d'un dispositif dont l'objectif n'est pas seulement de prévenir le premier usage mais également de prévenir le passage d'un usage régulier à un usage problématique.*
> *Du point de vue des enquêtes, il est important de cerner cette notion d'usage problématique et de graduer les consommateurs. Il est possible de le faire en essayant de repérer les consommations qui restent occasionnelles, celles qui sont sur des bases répétées ou régulières et celles qui sont problématiques.*
> *Actuellement, on tente de cerner trois critères de consommation. On tente de voir si le jeune consomme le cannabis de façon intensive ou journalière, s'il le consomme fréquemment seul, et s'il le consomme souvent le matin. Si on arrive à la conjonction de ces trois critères, je crois qu'on peut cerner un objet qui recouvre la notion d'usage problématique de cannabis. »*[23]

Pays-Bas

La situation des Pays-Bas est particulièrement intéressante considérant l'approche unique que ce pays a choisi de suivre dès 1976.[24] Les tendances d'usage ont fait l'objet d'une première enquête épidémiologique en population générale en 1997 et les résultats

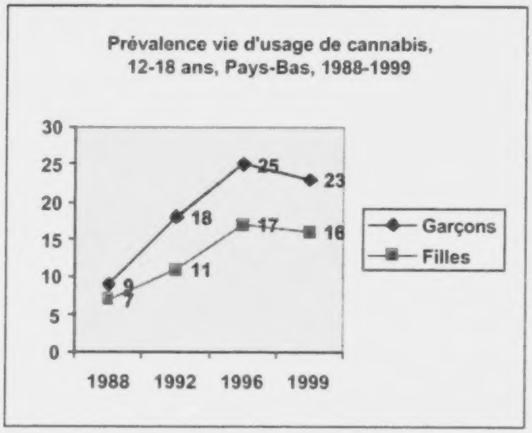
[22] *Ibid.*, page 101.
[23] M. Jean-Michel Coste, Directeur, Observatoire français des drogues et des toxicomanies, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 1er octobre 2001, fascicule no7, pages 31-32.
[24] Le chapitre 20 discute plus amplement des approches de politique publique dans divers pays.

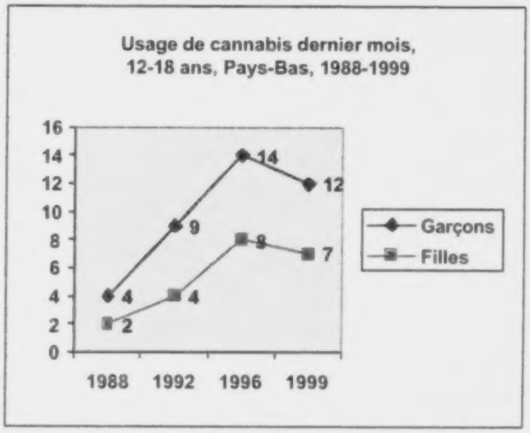
de la seconde (2001) devraient être connus prochainement. Les données indiquent, pour les personnes entre 15 et 64 ans, une prévalence-vie de 19,1 %, une consommation l'année précédente pour 5,5 % %, tandis que 2,5 % ont consommé au cours du dernier mois. Les nouveaux expérimentateurs au cours de l'année précédente représentent 1 % de la population et l'âge moyen des usagers est de 28 ans. Chez les 15-34, la prévalence-vie est de 31,8 % et l'usage au cours de la dernière année est de 14,2 %.

Parmi les usagers récents (au cours du dernier mois), la fréquence d'usage se répartit comme suit :

- 45 % ont consommé entre 1 et 4 jours au cours du mois
- 14 % entre 5 et 8 jours
- 15 % entre 9 et 20 jours
- 26 % plus de 20 jours.

Par ailleurs, les Pays-Bas ont mené des enquêtes auprès des étudiants entre 10 et 18 ans depuis 1984. Les données indiquent une augmentation significative de la prévalence-vie et de l'usage courant (dernier mois) comme le montrent les graphiques suivants (seules les données sur les 12-18 sont présentées.[25]



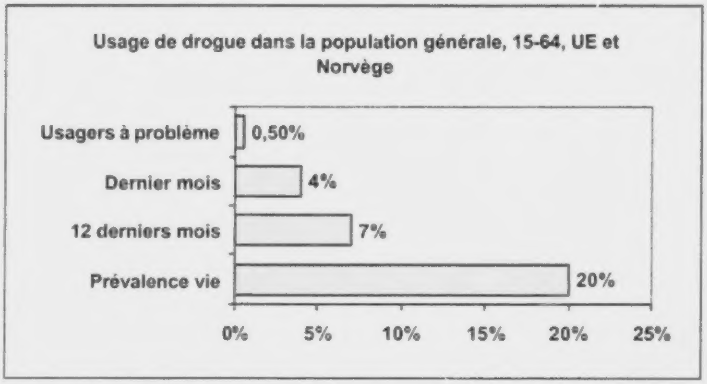


Comme dans les autres études, les garçons sont plus nombreux à consommer et la prévalence augmente avec l'âge : chez les 16-17 ans, la prévalence vie est de 43 % chez les garçons et de 31 % chez les filles et l'usage courant de 22 % et 11 % respectivement.

[25] Trimbos-Instituut (2000) *The Netherlands Drug Situation 2000.* Report to the EMCDDA. Disponible en ligne à l'adresse : http://www.emcdda.org/multimedia/publications/national_reports/NRnetherlands_2000.PDF

Tendances d'usage en Europe, 15-64

Les travaux de l'OEDT sur l'Europe et la Norvège permettent d'établir une gradation révélatrice de la nature des usages de drogues illicites. Le tableau ci-contre porte sur toutes les drogues illicites, mais l'on sait par ailleurs que le cannabis demeure dans tous les pays la drogue de choix pour au moins 90 % des usagers. Il est pertinent pour nos propos puisque, comme nous le verrons plus loin, nous tenterons d'estimer les proportions d'usagers selon les formes d'usage de cannabis au Canada.



Autrement dit, pour environ 50 millions de personnes qui ont expérimenté au moins une fois dans leur vie une drogue illicite, environ 17,5 millions en auraient fait usage au cours des 12 derniers mois, 10 millions au cours du dernier mois, et 0,5 % seraient considérés comme usagers à problème.

Comparaisons internationales

Malgré des différences significatives entre les modes d'enquête (type de questionnaire et de forme de passation), les indicateurs, les années étudiées et les âges, les tableaux suivants fournissent quelques indications précieuses sur la prévalence dans un ensemble de pays.

Le premier tableau donne des informations sur l'année de l'enquête, l'âge des répondants, et les proportions déclarant une prévalence de consommation de cannabis au cours de la vie et au cours de la dernière année. Aux fins de comparaison, nous ajoutons les données de la plus récente enquête ontarienne en population générale.

La prévalence-vie de consommation passe de 10 % en Finlande à 39 % en Australie, tandis que la consommation au cours de la dernière année passe de 1 % en Suède à 18 % en Australie. L'Ontario, avec des taux de 35 % et de 11 % figure parmi les endroits où la consommation de cannabis est la plus élevée.

Prévalence-vie et consommation dans la dernière année, population générale[26]

Pays	Année	Mode de collecte	Échantillon	âges	Prévalence-vie	Année dernière
Australie	1998	Mixte	10 000	14 +	39 %	18 %
USA	1999	Mixte	66 706	12 +	35 %	9%
USA	2000	Mixte	71 764	12 +	34 %	8 %
Royaume-Uni	2000	Mixte	13 021	16-60	27 %	9 %
Danemark	2000	Face-à-face	14 228	16-65	24 %	4 %
France	1999	Téléphone	11 526	15-65	23 %	8 %
Belgique	1998-1999	Téléphone	3 311	18-50	21 %	?
Allemagne	2000	Poste	6 332	18-60	21 %	6 %
Irlande	1998	Poste	10 415	15-65	20 %	9 %
Espagne	1999	Face-à-face	12 488	15-65	20 %	7 %
Pays-Bas	1997	Face-à-face	22 000	15-65	19 %	6 %
Suisse	1997	Téléphone	13 004	15-60	19 %	5 %
Grèce	1998	Face-à-face	3 752	15-65	13 %	4 %
Suède	2000	Face-à-face	2 000	15-65	13 %	1 %
Allemagne (est)	2000	Poste	1 430	18-60	11 %	5%
Finlande	1998	Poste	2 568	15-70	10 %	3 %
Ontario	2000	Téléphone	2 406	18 +	35 %	10,8 %

Le second tableau porte spécifiquement sur les jeunes.

Prévalence de la consommation chez les jeunes de 15-16 ans, 1995 et 1999[27]

Pays	Prévalence vie		Dernier mois		> 6 fois le dernier mois	
	1995	1999	1995	1999	1995	1999
USA	34 %	41 %	16 %	19 %	7 %	9 %
RU	41 %	35 %	24 %	16 %	9 %	6 %
France	-	35 %	-	22 %	-	9 %
Irlande	37 %	32 %	19 %	15 %	7 %	5 %
Pays-Bas	29 %	28 %	15 %	14 %	6 %	5 %
Italie	19 %	25 %	13 %	14 %	5 %	4 %
Danemark	17 %	24 %	6 %	8 %	1 %	1 %
Norvège	6 %	12 %	3 %	4 %	1 %	1 %
Finlande	5 %	10 %	1 %	2 %	0 %	1 %
Grèce	2 %	9 %	1 %	4 %	0 %	2 %
Portugal	7 %	8 %	4 %	5 %	1 %	2 %
Suède	6 %	8 %	1 %	2 %	0 %	0 %

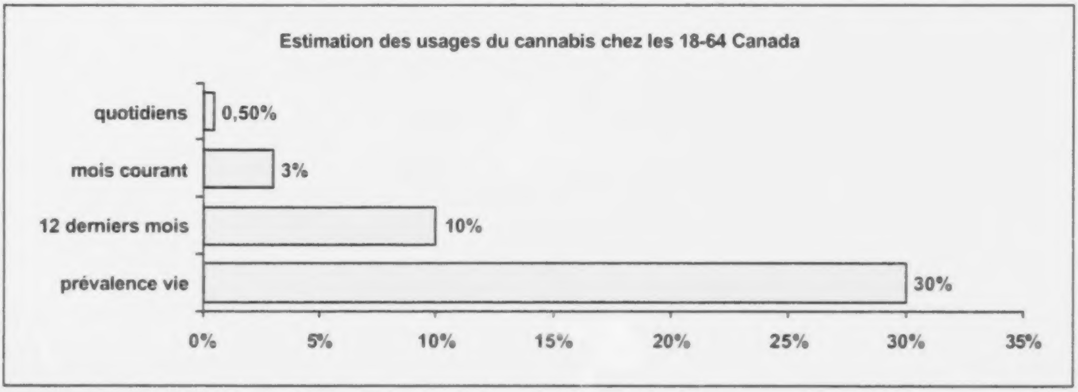
[26] Tableau adapté de Rigter, H. et M. von Laar (2002) « The Epidemiology of cannabis use. » in Pelc, I. (éd.), *International Scientific Conference on Cannabis*. Bruxelles.
[27] Tableau adapté de Rigter et von Laar, *op. cit.*, page 20.

Nous ne disposons pas de données immédiatement comparables pour le Canada. Reprenant les données ontariennes, on se souviendra que 40,7 % des étudiants de 10e en 1995 et 45 % en 2001 avaient consommé au moins une fois au cours de la dernière année. De même, 19 % en 1995 et près de 25 % en 2001 de l'ensemble des élèves de niveau secondaire consommaient plus de 6 fois par mois. On constate donc que, selon toute vraisemblance, les niveaux de consommation au Canada seraient parmi les plus élevés au monde pour cette classe d'âge.

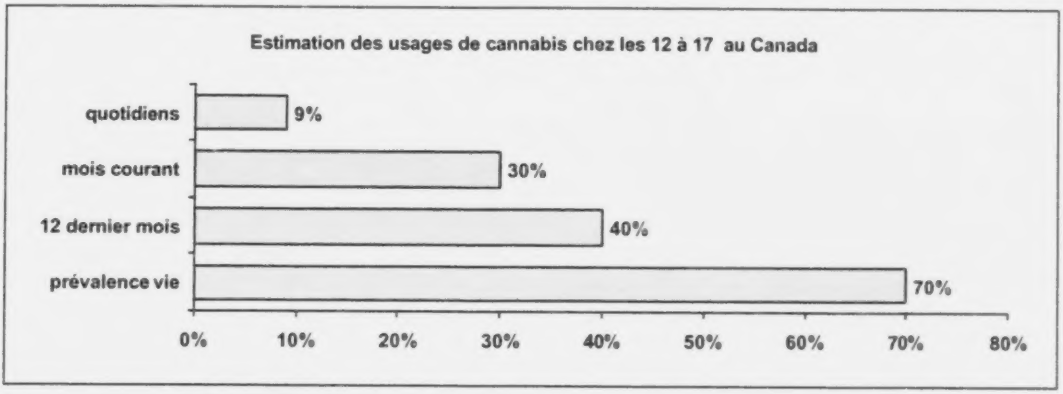
Éléments de synthèse

En l'absence de données récentes fiables sur le plan national, nous ne pouvons que faire des hypothèses. Pour la population de plus de 18 ans, il est permis de penser que la consommation de cannabis se répartirait comme suit :

Si l'on accepte les valeurs présentées dans ce graphique, et se basant sur une population estimée selon le dernier recensement à un peu plus de 20 millions de Canadiens ayant entre 18 et 64 ans, environ 2 millions d'entre eux ont eu au moins une expérience du cannabis au cours des 12 derniers mois, environ 600 000 en ont consommé au cours du dernier mois, et environ 100 000 en consommeraient quotidiennement.



Chez les jeunes entre 12 et 17 ans inclusivement, la situation pourrait ressembler à ce qui suit :



Selon le dernier recensement, la population des 12–17 se situerait à environ 2,5 millions. C'est dire qu'environ 1 million aurait consommé au cours des 12 derniers mois, 750 000 auraient fait usage au cours du dernier mois et 225 000 en feraient un usage quotidien.

Au total, ces tendances épidémiologiques tendent à indiquer plusieurs choses. Au niveau le plus simple, elles démontrent clairement un clivage générationnel et de genre : les personnes de moins de 35 ans consomment davantage que celles de plus de 35 ans et les hommes plus fréquemment que les femmes. Ce sont aussi plus souvent des personnes célibataires. Ces données semblent constantes tant depuis les premières études menées au cours des années 1960 qu'entre pays.

Par ailleurs, on observe aussi des modifications dans la composition des usagers. La part des 30 à 49 tend aussi à augmenter, ce qui pourrait, dans une certaine mesure, conforter l'hypothèse du NIDA selon laquelle on voit arriver ici les premières cohortes des usagers des années 1970. De même, si on avait tendance à identifier les usagers aux personnes de classe ouvrière ou aux chercheurs d'emploi dans les années 60, on note une augmentation chez les personnes ayant un emploi et un niveau d'éducation post-secondaire voire universitaire.

Certains auteurs relient l'usage au fait de vivre dans une zone urbaine – c'est le cas par exemple aux Pays-Bas où l'usage en zone métropolitaine est plus répandu que dans les zones rurales. Ce facteur ne s'applique pas au Canada : en Ontario par exemple, les étudiants à l'extérieur de Toronto consomment plus de cannabis que ceux vivant dans la conurbation torontoise. On associe aussi l'usage de cannabis au fait d'être non pratiquant, de provenir d'une famille où au moins l'un des deux parents a une éducation post-secondaire, et de provenir d'une famille monoparentale.[28]

L'âge d'initiation pourrait se produire plus jeune que durant les années 70, se situant entre 13 et 15 ans selon les études (environ 14 en moyenne en Ontario) tandis qu'il aurait été plus près des 16 ans. Par contre, l'initiation précoce, comme nous l'avons fait remarquer, serait en recul (2 % contre 8% au début des années 1980 en

[28] Voir Rigter, H. et M von Laar (2002) *op. cit.*.

Ontario). Si l'âge d'initiation semble être relié à une consommation régulière à la fin de l'adolescence et au début de l'âge adulte (18 à 25 ans) comme tendrait à l'indiquer les études américaines, il n'en reste pas moins que la consommation diminue avec l'âge et que le taux de discontinuation est élevé. Pour ceux qui continuent à consommer à long terme, l'âge de discontinuation serait repoussé vers la fin de la trentaine.

À un niveau plus complexe, ces tendances pourraient conforter l'hypothèse de l'OFDT d'une « banalisation » de la consommation de cannabis. On verra à la section suivante qu'un certain nombre de chercheurs – de même que des personnes ayant témoigné devant le Comité – imputent cette «banalisation » à une diminution de la perception des risques reliés à la consommation de cannabis (autant les conséquences pour la santé que la possibilité de conséquences judiciaires) et à une augmentation de la disponibilité du cannabis. Au delà d'une banalisation, on pourrait aussi invoquer une forme d'acculturation, au sens où le cannabis en viendrait à faire partie des substances psychoactives comme l'alcool et le tabac, c'est-à-dire des substances dont on apprend à connaître et à gérer les risques.

Au delà encore, on constate que les taux de consommation de cannabis varient largement entre pays sans lien apparent avec les politiques publiques. C'est l'une des hypothèses fortes sur lesquelles nous reviendrons plus amplement lorsque nous examinerons les régimes de politiques publiques au chapitre 20.

FORMES ET MODES D'USAGE

Pourquoi consomme-t-on du cannabis ? En fait, pourquoi les humains ont-ils senti le désir ou le besoin de consommer toutes sortes de substances psychoactives depuis aussi loin que la mémoire remonte ? Ces questions, on s'en doute, sont éminemment chargées de sens symbolique et politique : quand il est question du cannabis, tantôt on insistera sur son aspect « drogue douce », son côté festif et sociable, tantôt on voudra plutôt faire ressortir son inscription dans une trajectoire marginale sinon pré-délinquante et les risques associés au passage vers d'autres drogues. En fait, on connaît somme toute, et étonnamment, bien peu de choses sur les motivations et expériences des consommateurs.

On peut distinguer deux grands groupes d'études : des études socio-anthropologiques cherchant à identifier les pratiques des usagers et certains facteurs du milieu permettant de les mettre en contexte, et des études psychologiques cherchant à relier des facteurs de personnalité et d'origine familiale à la consommation de cannabis. Si les deux types d'études sont tout aussi pertinents pour saisir la nature du phénomène, leurs approches et leurs résultats sont souvent difficiles à concilier. Mais d'abord quelques éléments d'histoire sur les usages du cannabis.

Le cannabis dans l'histoire [29]

Bien que les itinéraires historiques du cannabis demeurent encore obscurs, des archéologues ont découvert un village chinois où l'on retrouverait la plus ancienne utilisation de la plante de cannabis, soit environ 10 000 ans. Elle était principalement utilisée pour faire des vêtements, des câbles et filets de pêche, du papier, et d'autres fins décoratives. Elle était aussi considérée comme l'une des cinq céréales de la Chine. Vers 2 000 avant Jésus-Christ, on se serait aperçu des propriétés psychotropes et médicinales de l'huile (résine) de cannabis, notamment pour traiter les cas de fatigue menstruelle, de goutte, de rhumatisme, de malaria, de constipation, de manque de concentration et comme anesthésiant. On a identifié aussi des utilisations à caractère religieux, notant que son utilisation permettait de communiquer avec les esprits et d'alléger le corps. Au premier siècle avant Jésus-Christ, les taoïstes utilisaient les graines de cannabis dans leurs encensoirs pour provoquer des hallucinations qu'ils considéraient comme une façon d'atteindre l'immortalité.

Plusieurs historiens attribuent l'origine du cannabis aux Scythes vers le VIIe siècle avant J.C. autour de la Sibérie et de l'Asie centrale du Nord. Selon Hérodote, historien grec ayant vécu au cinquième siècle avec le Christ, la marijuana faisait partie intégrale du culte des morts que les Scythes suivaient pour rendre hommage à la mémoire et à l'esprit de leurs chefs disparus. On a aussi retrouvé des traces de consommation de cannabis, souvent à des fins religieuses, chez les Sumériens ainsi que, selon certains, dans certains passages de la Bible.

La première description ethnographique de l'inhalation de marijuana par des peuples anciens comme stimulant psychotrope a été confirmée par un anthropologue russe, Rudenko, en 1929. Non seulement a-t-il trouvé le corps embaumé d'un homme et un chaudron de bronze rempli de graines de marijuana brûlées, mais il a également trouvé des chemises de tissu de fibres de chanvre et des encensoirs métalliques conçus pour inhaler la fumée de marijuana. Cette activité n'était apparemment pas de nature religieuse mais une activité quotidienne à laquelle participaient les hommes comme les femmes, comme le confirmerait la découverte du corps congelé d'une femme de 2 000 ans dans le même cimetière où Rudenko avait fait sa première découverte. Les archéologues ont trouvé enterré dans un tronc d'arbre creux quelques-unes de ses possessions, dont un petit contenant de cannabis qui aurait été fumé pour le plaisir et utilisé dans des rituels.

En Inde, le cannabis est étroitement associé aux coutumes magiques, médicales, religieuses et sociales depuis des milliers d'années. D'après une légende trouvée dans les Vedas, Siva est décrit comme «le Seigneur du bhang » une boisson faite avec des feuilles de cannabis, du lait, du sucre et des épices. Cette boisson fait encore partie des traditions de certaines castes. Le cannabis y est aussi reconnu pour son utilisation dans

---

[29] Cette section s'inspire largement de Spicer, L. (2002) *Utilisations historiques et culturelles du cannabis et le « débat sur la marijuana » au Canada*, Ottawa : Bibliothèque du Parlement, rapport préparé pour le Comité spécial du Sénat sur les drogues illicitres. Disponible en ligne à : www.parl.gc.ca/drogues-illicites.asp

les pratiques sexuelles du tantrisme. Environ une heure avant le rituel du yoga, le pratiquant boit un bol de bhang après avoir récité un mantra à la déesse Kali. De même, le « charas » occupe une place particulière dans les cérémonies de prières appelées pujas. Enfin, le cannabis a été utilisé à des fins médicales.

Bien qu'elle ne soit pas originaire de l'Afrique, la plante de cannabis fait partie de traditions religieuses, médicales et culturelles sur presque tout le continent. En Égypte, elle est cultivée depuis plus de 1000 ans, tandis que les premières preuves de sa présence dans les parties centrale et méridionale la situent en Éthiopie du XIVe siècle où des fourneaux de pipe en céramique contenant des traces de cannabis ont été découverts. En Afrique du Nord, le cannabis a influencé la musique, la littérature et même certains aspects de l'architecture puisque dans certaines maisons une pièce était réservée au kif où les membres de la famille se rassemblaient pour chanter, danser et raconter des récits. La plante était aussi utilisée comme remède contre les morsures de serpent (Hottentots), pour faciliter l'accouchement (Sotho) ou contre l'anthrax, la malaria, la fièvre bilieuse et l'empoisonnement du sang (Rhodésie).

En Amérique du Sud, ce seraient principalement les esclaves importés d'Afrique qui auraient amené le cannabis. Dans les Antilles, notamment en Jamaïque, les travailleurs des Indes orientales ont amené le cannabis, où il est non seulement à usage récréatif mais est intégré à de nombreuses dimensions de la culture jamaïcaine et au culte rastafari notamment.

Quant à l'Amérique du Nord, on ne sait pas au juste quand les propriétés psychotropes du cannabis ont été découvertes. Certains pensent qu'il jouait un rôle dans plusieurs cultures autochtones, d'autres doutent qu'il ait jamais joué un rôle important. La preuve la plus ancienne de l'existence du cannabis en Amérique du Nord remonte à Louis Hébert, apothicaire de Champlain, qui a fait connaître le cannabis aux colons blancs en 1606, essentiellement comme fibre servant à faire des vêtements, des cordages, des voiles et des câbles de bateau. Ses propriétés psychotropes n'auraient cependant été découvertes qu'au XIXe siècle. Entre 1840 et 1900, il a été utilisé dans la pratique médicale dans presque toute l'Amérique du Nord. Il était prescrit pour diverses affections telles la rage, le rhumatisme, l'épilepsie, le tétanos et comme relaxant musculaire. Son utilisation était d'ailleurs tellement répandue que des préparations de cannabis étaient vendues librement dans les pharmacies.

La première étude du cannabis a été effectuée en 1860 par la *American Governmental Commission*. Le Dr Meens, présentant les constatations de la Commission à la *Ohio State Medical Society* disait :

> [Traduction] *« Les effets du cannabis sont moins intenses que ceux de l'opium et les sécrétions ne sont pas tout à fait supprimées par son utilisation. La digestion n'est pas perturbée ; l'appétit a tendance à augmenter ; l'effet du chanvre dans son ensemble est moins violent et produit un sommeil plus naturel, sans nuire au fonctionnement des organes internes ; il est certainement préférable à l'opium dans bien des cas et il ne se compare pas à cette drogue sur les plans de la force et de la fiabilité. »*[30]

[30] Cité dans Spicer, *op. cit.*, page 29.

En même temps, d'autres médecins critiquaient son utilisation en raison de la variabilité et de l'incertitude de ses effets. Quant à ses utilisations récréatives, elles semblent avoir été notées pour la première fois au début du XXe siècle, et ont rapidement fait l'objet de préoccupations sociales, notamment en raison de l'association du cannabis aux travailleurs mexicains puis aux noirs américains, renforçant des craintes quant à ses effets criminogènes et aphrodisiaques. La Californie a été le premier état à prohiber la possession de cannabis en 1915. Le Canada en a fait autant en 1923, tandis que les États-Unis en interdisaient la possession à partir de 1937. Pourtant, dès 1944, le rapport La Guardia, de l'État de New York, insistait sur les effets inoffensifs du cannabis. Il sera suivi des rapports de la Commission Le Dain au Canada et de la Commission Schafer aux États-Unis au début des années 1970. Sur la scène internationale, le cannabis était interdit par la Convention unique de 1961 (dont il sera plus amplement question au chapitre 19).

Au Canada, l'utilisation massive du cannabis s'est manifestée à partir des années 1960. Auparavant, le phénomène était à peu près invisible et il n'y avait eu que 25 condamnations pour possession de cannabis entre 1930 et 1946. En 1962, la GRC rapportait 20 cas liés au cannabis. Puis ce fut l'explosion que l'on connaît : 2 300 cas en 1968 et 12 000 condamnations liées au cannabis en 1972. Selon la Commission Le Dain, on peut attribuer l'évolution soudaine de l'utilisation du cannabis aux hippies, à la guerre du Vietnam, aux journaux clandestins, et à l'influence des mass média. S'ajoute à ces grands courants de contre-culture l'ouverture sur le monde dans les deux sens : de plus en plus de jeunes Canadiens voyagent, cependant que le Canada reçoit lui aussi de plus en plus de visiteurs et d'immigrants. Depuis lors, à l'exception de quelques années, l'utilisation du cannabis à des fins non médicales s'est accrue, comme nous l'avons vu dans la section précédente.

Trajectoires d'usages

La plupart des études distinguent les usages selon les quantités et la fréquence de consommation. Ainsi par exemple, le rapport de l'OFDT, comme nous l'avons vu à la section précédente, distinguait entre les usages (expérimental, occasionnel, répété, régulier et intensif), la fréquence de la consommation (nombre de fois par mois) et ses modalités (seul ou en groupe, le matin ou le soir) étant des indicateurs privilégiés pour les usages à risque. Pourtant, cette connaissance de certaines caractéristiques de la consommation, notamment chez les jeunes, indique peu de choses sur la suite. Arrêtant le temps à un moment donné de l'histoire de l'usager, elles ne permettent pas de savoir ce qui se passe ensuite. Ces données ne permettent pas, par exemple, de répondre à la question de savoir si une consommation de cannabis initiée à l'adolescence s'inscrit sur une trajectoire qui mène vers une consommation accrue. Or, un certain nombre d'intervenants qui ont témoigné devant le Comité nous ont dit observer une dépendance chez les usagers de cannabis. De même, certains documents

gouvernementaux, aux USA notamment, n'hésitent pas à pointer dans cette direction en mesurant la demande de traitement et en rapportant que la demande de traitement pour dépendance au cannabis est en augmentation. Par exemple, des documents que nous ont remis les responsables américains sur les drogues indiquent que 40 % des personnes dépendantes selon les critères diagnostics du DSM IV (dont il sera question au chapitre suivant) ont un diagnostic primaire de dépendance au cannabis.[31] À moins de penser que la dépendance s'installe après quelques usages occasionnels, force est de penser qu'un nombre relativement important de jeunes qui s'initient au cannabis à l'adolescence poursuivront une trajectoire d'usagers qui les mènera à la dépendance.

Mais qu'en est-il vraiment ? Quelles sont les trajectoires des usagers ? Quelles n sont les étapes ? Peut-on discerner une progression ?

Soulignons d'abord, avec le professeur Mercier, que la notion de trajectoire est elle-même un peu inexacte.

> *« La notion de trajectoire est d'abord basée sur le principe de base que les individus passeront par un certain nombre d'étapes ou de phases successives. Il est vrai que la notion de trajectoire est un peu fausse. Une trajectoire est un peu une métaphore de la trajectoire des planètes et des étoiles, c'est-à-dire quelque chose de très orienté et dans un mouvement continu. Le mot « trajet » serait plus juste. Dans un trajet, il y a des détours et des allers-retours, etc. Il faut donc garder à l'esprit que cette notion de trajectoire n'est pas nécessairement linéaire, mais qu'il y aura différentes modalités et différents sentiers, « journeys » est le terme le plus juste pour décrire les rapports qu'un individu aura avec les substances psychotropes au cours de sa vie. Il y a aussi une autre notion importante. On parle de trajectoires, de phases, d'étapes, mais il y a des transitions, des moments charnières où les individus passeront d'une étape à une autre. »*[32]

Certains, comme le rapport de l'INSERM, parlent de phases de contact, d'expérimentation, et d'engagement. Le contact c'est le fait de connaître des personnes qui en consomment ou de voir du cannabis. L'expérimentation, c'est bien sûr le fait d'essayer, qui peut se limiter à une seule fois. Enfin, l'engagement réfère à diverses modalités de gérer l'usage, allant de l'engagement relatif où l'usage subit des variations importantes à l'engagement réel où il y a moins de variations. Le rapport précise que ces trois étapes ne se présentent pas dans toutes les trajectoires ni ne se succèdent toujours de manière cohérente. De surcroît, il y aura souvent des périodes d'arrêt, suivies de reprise ou d'un arrêt définitif. Néanmoins, selon l'INSERM, « *les engagements constituent probablement l'étape la plus importante si l'on désire comprendre à quoi correspondent les usages du cannabis. C'est cependant sur ces engagements que les données semblent les plus inconsistantes, la plupart des travaux portant sur l'initiation.* »[33]

---

[31] Office of National Drug Control Policy (2002) *National Drug Control Strategy*. Washington, DC : The White House.

[32] Professeure Céline Mercier, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 10 décembre 2001, fascicule no 12, page 6.

[33] INSERM (2001) *op. cit.*, page 28.

En effet, les données sur l'engagement dans une utilisation demeurent très fragmentaires de sorte qu'au delà de quelques généralités on connaît somme toute peu de choses sur les modalités et trajectoires d'usage du cannabis. En fait, tout se passe comme si l'on était d'abord préoccupé de classifier les usagers selon le degré de risque de dépendance qu'ils présentent, ou de leur appliquer un modèle déjà tout fait. Lors de son témoignage devant le Comité, la professeure Mercier a rappelé les cinq étapes du schéma classique de la toxicomanie : initiation, installation progressive dans l'abus, dépendance, traitement et réinsertion. Pourtant, comme elle le souligne, ce n'est là qu'une des trajectoires possibles, celle qui a été la plus fréquemment étudiée en matière de drogues (notamment alcool, héroïne et cocaïne), et qui cependant ne s'applique que très peu au cas du cannabis. Il est certain en tout cas qu'il y a, au sein des usagers de cannabis, une grande variabilité d'usages.

Les données épidémiologiques présentées à la section précédente indiquent déjà que la consommation de cannabis diminue de façon importante avec l'âge. Plus précisément, le taux de discontinuation est important comme le démontre le tableau suivant.

Taux de discontinuation (pourcentage des usagers vie qui n'ont pas consommé au cours de l'année précédente), USA, 1996[34]

Groupe d'âge	Femmes	Hommes
12-17	26 %	20 %
18-25	54 %	39 %
26-34	82 %	74 %
35 +	91 %	82 %

À l'opposé, le taux de continuation est relativement faible : il est de 24 % aux USA en 2000, 17 % au Danemark, 29 % en France et en Allemagne (ouest), 24 % en Suisse et 8 % en Suède. La seule exception est l'Australie avec un taux de continuation de 46 %.

Ceci étant, ces données ne disent rien de la durée pendant laquelle se poursuit cette continuation de la consommation de cannabis ni de la fréquence de l'usage ni des quantités consommées. Les études épidémiologiques tendent à établir que la plupart des usagers discontinuent au cours de la trentaine, mais seules des études de type ethnographique peuvent nous renseigner davantage. Malheureusement il en existe peu.

Le rapport de l'INSERM décrit des études menées en Australie, en France, et aux États-Unis. La plupart révèlent l'évolution vers des usages régulés du cannabis, c'est-à-dire des usages à la fois stabilisés – moins de variations dans les consommations – et

[34] Rigter, H. et M. von Laar, *op. cit.*, page 27.

des usages qui sont plus intégrés aux conditions sociales d'existence, c'est-à-dire à la vie de couple et à la vie professionnelle. Une proportion importante des consommateurs réguliers sur la longue durée sont des hommes, ont plutôt tendance à être célibataires et à travailler dans des professions liées à la création. La plupart disent consommer pour relaxer et soulager le stress, favoriser le sommeil, ou modifier leurs états de conscience.[35]

Au Canada, Hathaway a mené une étude sur des consommateurs réguliers.[36] Menée sur base d'entretiens qualitatifs entre octobre 1994 et juin 1995, l'étude porte sur un échantillon de 30 consommateurs réguliers (15 hommes et 15 femmes) âgés entre 22 et 47 ans (moyenne de 32 ans). Les participants avaient consommé pendant des périodes entre 3 et 31 ans, la moyenne étant de 17 ans ; 40 % avaient fait un usage quotidien pendant 20 ans ou plus. Ses données vont largement dans le sens de ce que suggère l'INSERM. Les consommateurs au long cours intègrent leur consommation régulière de cannabis à leur vie quotidienne et à leurs activités sociales tout en conservant la conscience de la valeur symbolique de cette «déviance tolérée». Si la plupart ont commencé au contact d'un petit groupe d'usagers qui a pu leur servir plus ou moins longtemps de support, les consommateurs les plus en harmonie avec leur usage de la drogue sont ceux qui ont développé une régulation autonome de leur usage.

> [Traduction] *« Dans cette étude, j'ai observé que le passage d'un mode de consommation dépendant du niveau de participation aux usages de groupe à un mode régulé de manière autonome est crucial dans la relation entretenue avec la marijuana. (...) l'usage continu de la drogue ne signifie pas une incapacité à s'engager dans des rôles adultes conventionnels. Plutôt, la capacité d'adapter l'usage de marijuana aux autres dimensions d'une vie par ailleurs conventionnelle rend la pratique plus signifiante sur un plan personnel que les pratiques antérieures dépendantes de l'appartenance au groupe d'usagers. »* [37]

Cette acculturation de la drogue se produira, pour un certain nombre d'usagers, après une période d'abstinence plus ou moins prolongée pendant laquelle ils prendront leur distance par rapport au groupe d'usagers. Il leur est alors possible de définir pour eux-mêmes la place de leur consommation dans leur vie. Tous les participants à l'étude avaient d'ailleurs réussi à intégrer leur consommation à leur situation de vie familiale ou professionnelle. Les usagers associent leur consommation de drogue principalement aux temps libres et à la relaxation après une journée de travail, certains la comparant à la place de l'alcool. Bien que 97 % en faisaient un usage au moins hebdomadaire et 37 % un usage quotidien, seulement 7 % (2 personnes) définissaient leur usage comme problématique. La plupart passaient par des périodes d'abstinence ou de diminution de leur consommation sans ressentir de difficultés.

---

[35] INSERM (2001), *op. cit.*, pages 55-58.

[36] Hathaway A. D. (1997a) « Marijuana and lifestyle : exploring tolerable deviance. » *Deviant Behavior : An Interdisciplinary Journal*, 18, pages 213-232 ; et (1997b) «Marijuana and tolerance : revisiting Becker's sources of control. » *ibid.*, pages 103-124.

[37] Hathaway, A.D. (1997a), *op. cit.*, page 219.

Une autre étude, rapportée par Rigter et von Laar,[38] a été menée dans l'État de New York sur une cohorte de consommateurs suivis sur une période de vingt ans. Cette étude a permis d'identifier quatre types de consommateurs :

- Début précoce / usage intensif: commencent vers 15 ans et deviennent des usagers réguliers vers 17,5 ans; connaissent une consommation quotidienne en moyenne pour une durée de 131 mois; 49 % consomment encore vers 34-35 ans ;
- Début précoce / usage léger : commencent vers l'âge de 15 ans mais sont moins nombreux (44 %) à passer à un usage quotidien (d'une durée de 28 mois en moyenne); seuls 10 % d'entre eux consomment encore à 34-35 ans ;
- Début médian / usage intensif: commencent vers 16 ans; deux tiers deviennent usagers quotidiens (durée moyenne de 42 mois) et consomment encore à l'âge de 34-35 ans ;
- Début tardif / usage léger : commencent à l'âge de 19,5 ans et une minorité deviennent usagers journaliers (21 %). Presque tous discontinuent vers 34-35 ans.

Au total, l'étude démontrait qu'il y avait nettement plus d'usagers légers que d'usagers intensifs. Ceux-ci avaient une scolarité inférieure, allaient moins souvent à l'église, avaient un passif délinquant plus fréquent, et changeaient plus souvent d'emploi. Les usagers précoces démontraient une tendance plus élevée à des épisodes de délinquance et des désordres mentaux, avaient commencé à boire et à fumer du tabac plus tôt, avaient davantage tendance à expérimenter d'autres drogues, et une tendance à identifier des raisons positives pour consommer de la marijuana.

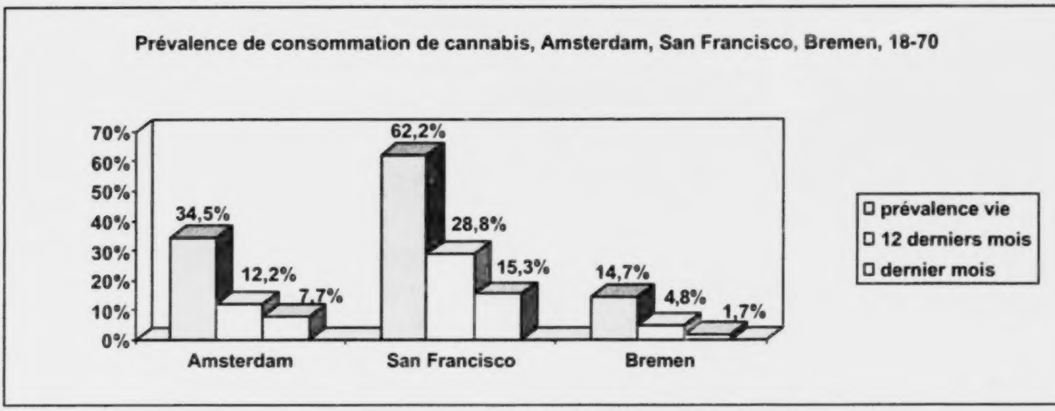
Mais il est risqué de proposer des typologies car les frontières sont fluides et les usagers passent d'un type de consommation à l'autre assez facilement. C'est ce que démontre notamment l'étude comparative de Cohen et Kaal menée à Amsterdam, San Francisco et Bremen.[39]

---

[38] Rigter, H. et M. von Laar, *op. cit.*, pages 28-29.

[39] Cohen, P.D.A. et H.L. Kaal, (2000) *The irrelevance of drug policy. Patterns and careers of experienced cannabis use in the population of Amsterdam, San Francisco and Bremen.* Amsterdam : University of Amsterdam, CEDRO.

L'étude porte sur un échantillon de consommateurs expérimentés composé de 216 personnes à Amsterdam, 265 à San Francisco et 55 à Bremen. L'intérêt de la méthode sophistiquée de sélection des répondants à partir des enquêtes épidémiologiques menées en population générale pour ces villes est de permettre d'établir la prévalence de l'usage. La figure suivante reproduit ces données.



L'âge moyen des participants variait entre 33 et 37 ans, la plupart avaient un conjoint et un emploi stable. L'âge moyen d'initiation au cannabis dans les trois villes était de 16 ans, soit à un plus jeune âge que chez les personnes qui n'ont qu'une exposition occasionnelle au cannabis (21,2 à Amsterdam, 19,5 à Bremen). La plupart ont été initiés par des amis et ont consommé en groupe lors de leur première expérience. À 19 ans, ils en faisaient un usage régulier (au moins une fois par mois) et leur usage le plus intensif était vers 21,5 ans. Les trajectoires d'utilisation ont été déterminées à partir de six modèles :

1) Du plus vers le moins : après une période de consommation intense au début, la personne diminue graduellement sa consommation.
2) Graduellement plus : la personne augmente régulièrement son usage.
3) Stable : les quantités et la fréquence n'ont pas changé.
4) Up top down : la consommation augmente, atteint un plateau et diminue ensuite.
5) Intermittente : arrêts fréquents après l'initiation.
6) Variable : consommation en dents de scie.

Comme l'indique le tableau suivant, pas moins de 75 % des répondants dans les trois villes correspondent aux modèles 4 (48,7 %) et 6 (25 %).

Modèles de consommation chez les usagers réguliers[40]

	Amsterdam		San Francisco		Bremen	
	Nombre	%	Nombre	%	Nombre	%
Modèle 1	17	8	18	7	-	-
Modèle 2	13	6	17	6	6	11
Modèle 3	24	11	5	2	5	9
Modèle 4	104	48	133	50	24	44
Modèle 5	7	3	25	9	2	4
Modèle 6	51	24	66	25	18	33

À la période la plus intense de leur consommation, environ 45 % consommaient régulièrement. Par ailleurs, au cours de la dernière année, environ 35 % consommaient moins d'une fois par semaine et plus de 35 % pas du tout. Au cours des trois derniers mois, plus de 50 % n'ont pas consommé du tout, et moins de 10 % consommaient sur une base journalière. Quant aux quantités, les auteurs de l'étude concluent qu'ils sont faibles : à leur période d'usage intensif, moins de 18 % fumaient plus d'une once par mois, tandis qu'au cours de la dernière année, environ 60 % fumaient moins de 4 grammes (1/7 once) par mois. Les usagers se répartissent à peu près également entre ceux qui préfèrent un cannabis moyen ou doux et ceux qui préfèrent une variété plus puissante (avec une plus nette préférence pour les variétés douces à Amsterdam). Les usagers entourent leur consommation d'un certain nombre de règles : ne fument pas au travail ou à l'école (plus de 35 %), durant le jour, ou le matin.

La plupart des usagers au long cours ont eu des périodes d'abstinence variant entre un mois et un an ou plus, le plus souvent parce qu'ils ne sentent plus le besoin ou le goût de fumer. Par ailleurs, entre le tiers et la moitié ont décidé de réduire leur consommation à divers moments.

On voit donc que les trajectoires des usagers ne suivent pas une progression linéaire, qu'elles sont marquées par des périodes clés d'intégration de la consommation aux dimensions de la vie sociale et personnelle, de distanciation par rapport au groupe d'usagers, de stabilisation de la place de la marijuana dans la vie personnelle, avec des périodes de consommation intenses surtout en début de trajectoire suivies de périodes soit de diminution, soit de hauts et de bas en termes de fréquence et de quantités.

Facteurs reliés à l'usage

Faisant suite logiquement avec ce que nous avons vu à la section précédente, les études sur les facteurs pouvant expliquer l'usage de drogues, de cannabis en particulier, portent principalement sur l'initiation ou l'expérimentation.

Le rapport de l'INSERM examine un ensemble d'études sur les facteurs pouvant expliquer l'usage de cannabis : l'influence du milieu familial (usage par les parents,

[40] *Ibid.*, page 48.

socialisation, modes éducatifs parentaux, qualité des liens parents enfants, modèles parentaux), des pairs (valeurs symboliques de la consommation, normes), et des milieux scolaire et social.[41] Il n'en tire pas de conclusion claire, mais note que les études arrivent peu ou mal à tenir compte de l'inscription des usagers dans des milieux sociaux et conséquemment des impacts différentiels sur l'usage tenant de la variabilité des stress sociaux ainsi que des modalités d'intégration. Ajoutons aussi que ces études ne tiennent pas compte des trajectoires d'usage.

Observons d'abord avec *Drugscope* que l'approche épidémiologique à l'analyse de la consommation de drogues, de cannabis en particulier, repose sur un modèle médical d'analyse de la prévalence de maladies, alors que les raisons (qui ne sont pas nécessairement des causes) à l'usage de drogues peuvent très bien être étrangères au domaine médical et plus largement au modèle psychosocial. L'attribution de la dépendance – entendue ici au sens d'une maladie – à des facteurs tenant à la relation entre le lieu de contrôle (*locus of control*) et l'environnement a des conséquences aussi bien pour la compréhension du phénomène que pour les politiques publiques. Le rapport de cet organisme britannique présente un tableau des explications de l'usage de drogues que nous croyons utile de reproduire ici.

Attributions pour expliquer l'usage de drogues[42]

Attribution	Explication de sens commun	Politiques publiques en découlant
Interne x stable	L'usage de drogues est une maladie (modèle de la dépendance)	Modèle du traitement
Interne x instable	L'usage de drogues est la recherche périodique du plaisir	Modèle de réduction de la demande (remplacer les drogues par autre chose)
Externe x stable	Des carences dans l'environnement expliquent l'usage de drogues	Modifier l'environnement
Externe x instable	La disponibilité des drogues explique l'usage	Modèle de la réduction de l'offre

Il ne faut pas perdre de vue en effet qu'en matière de substances psychoactives, le modèle médical de la maladie est encore un modèle de compréhension dominant et qu'il forme l'autre partie de la réponse publique avec le modèle pénal.[43] Comme on nous l'a répété à plusieurs reprises, les drogues, le cannabis en particulier, ne sont pas dangereuses parce qu'elles sont illégales, mais elles sont illégales parce que dangereuses.

---

[41] INSERM (2001) *op. cit.*, pages 28-50.

[42] DrugScope (2001) *United Kingdom. Drug Situation 2000.* Report to the EMCDDA, page 19.

[43] Là dessus, voir par exemple les travaux de Bergeron, H. (1996) *Soigner la toxicomanie. Les dispositifs de soin entre idéologie et action.* Paris : L'Harmattan ; et Barré, M.D., M.L. Pottier et S. Delaître (2001) *Toxicomanie, police, justice : trajectoires pénales.* Paris : OFDT.

Nous aurons l'occasion de commenter cette affirmation plus amplement dans les chapitres suivants.

Pour l'instant, il suffit de retenir que les tentatives d'explication de l'usage de drogues passent le plus souvent par la recherche de déficiences dans la personnalité ou dans l'environnement plutôt que par une recherche de compréhension des choix faits par les usagers.

Parmi les facteurs reliés au lieu de contrôle, les études identifient principalement :

- L'influence des pairs : les premiers usages seraient fonction de l'influence d'autres jeunes dans l'entourage ;
- L'influence du milieu familial : un milieu familial où la supervision parentale ferait défaut, où la consommation de drogues serait tolérée, où des membres de la fratrie ou les parents seraient criminalisés, et où les parents sont eux-mêmes consommateurs ;

Parmi les facteurs reliés à l'environnement, les études citent :

- La disponibilité et l'accessibilité des drogues : plus les drogues sont disponibles, plus la consommation sera élevée ;
- La tolérance sociale : plus l'usage de drogues est accepté, plus les niveaux de consommation seront élevés ;
- La perception du risque : moins les risques de désapprobation sociale, ou les risques perçus sur la santé, ou les risques de judiciarisation sont élevés, plus la consommation sera élevée.

Selon le rapport *Monitoring the Future* il ne fait pas de doute que les perceptions et attitudes qu'ont les jeunes à l'égard des drogues sont déterminantes des niveaux de consommation, ce qui en retour doit déterminer les politiques publiques :

> [Traduction] *« Au début des années 1990 nous avions observé une augmentation de l'usage d'un certain nombre de drogues illicites chez les élèves de niveau secondaire et des changements importants de certaines attitudes et croyances clés relativement à l'usage de drogues. (…) Spécifiquement, la proportion d'entre eux qui considéraient que l'usage de drogues présentait des risques avait commencé à diminuer ainsi que la proportion de ceux qui étaient en désaccord avec l'usage. Comme nous l'avions alors prédit, ces changements annonçaient la fin de l'amélioration de la situation des drogues que la nation avait fini par prendre pour acquise. L'usage de drogues illicites augmenta significativement à chacun des trois niveaux après 1992, tandis que les attitudes et opinions négatives continuaient de prendre du plomb dans l'aile. Cette tendance s'est poursuivie pendant quelques années. »* [44]

Et plus loin :

[44] Johnston, L.D., et coll., (2001) *op. cit.*, page 6.

[Traduction] *« Nous pouvons résumer les données sur les tendances comme suit : pendant plus d'une décennie – de la fin des années 1970 au début des années 1990 – l'usage de drogues illicites avait diminué de façon appréciable chez les élèves de douzième année, et de manière encore plus importante chez les étudiants de collège et les jeunes adultes. Ces améliorations substantielles – qui semblent largement explicables par des modifications dans les attitudes au sujet de l'usage de drogues, les croyances relatives aux risques associés à l'usage, et les normes des pairs – ont des implications très importantes en ce qui concerne les politiques. La première est que les comportements d'usage des jeunes américains sont malléables – ils peuvent être modifiés. Cela a été fait auparavant. La seconde est que les facteurs relatifs à la demande semblent avoir joué un rôle déterminant dans les modifications constatées. Les niveaux de disponibilité de la marijuana tels que les rapportent les élèves de fin du cycle secondaire sont demeurés relativement stables au cours de la période de l'étude. (De plus, les abstinents et ceux qui discontinuent l'usage disent que ni le prix ni la disponibilité ne sont des raisons importantes dans leurs décisions.) D'ailleurs, la perception de la disponibilité de la cocaïne augmentait tandis que l'usage de cocaïne et de crack chutait brutalement et que les risques associés à l'usage de ces drogues augmentaient significativement. (…) Au fil des ans, cette étude a démontré que les changements dans les risques perçus et la désapprobation de l'usage ont été des causes de modification dans les niveaux d'usage de diverses drogues. Ces croyances et ces attitudes sont certainement influencées par le niveau et la nature des messages publics au cours de la période de croissance de ces jeunes. La diminution significative de l'intérêt porté à la question des drogues au début des années 1990 peut aider à expliquer pourquoi la perception des risques et la désapprobation chez les adolescents ont commencé à diminuer. »* [45]

En d'autres termes, la désapprobation sociale – par les campagnes gouvernementales d'information par exemple – peut générer des attitudes de rejet de l'utilisation qui seront renforcées par des actions susceptibles d'augmenter les risques reliés à l'utilisation (par exemple les risques d'arrestation).

On trouve un exemple d'application de cette approche au Canada dans une étude réalisée à Terre-Neuve et Labrador sur un échantillon de 3 293 personnes.[46] Le questionnaire comportait des questions sur les activités (en famille, travail domestique, activités parascolaires, travail scolaire, sports, travail, vie religieuse), la disponibilité du cannabis, l'utilisation par les parents, les pairs, et soi-même, les normes parentales et des pairs sur l'utilisation du cannabis, les préférences et normes personnelles sur le cannabis. L'analyse de variance porte sur l'interaction entre ces diverses variables pour expliquer l'usage personnel de cannabis. Le modèle dans son ensemble n'explique que 57 % de l'usage sur l'échantillon provincial, dont 65 % pour les garçons et 54 % pour les filles. Les résultats montrent que l'utilisation par les pairs est le principal facteur relié à l'usage personnel (29 % de la variance), suivi par les préférences personnelles (elles-mêmes influencées par les normes des pairs), les normes personnelles et le fait d'avoir des tâches domestiques. La disponibilité n'est pas directement reliée à l'usage et passe par l'usage et les normes des pairs. L'usage parental est fortement relié à la

[45] *Ibid.*, page 30.

[46] Wasmeier, M., et coll., (2000) *Path analysis survey of substance use among Newfoundland and Labrador Adolescents. Marijuana / haschich and Solvent use.* Memorial University of Newfoundland.

disponibilité perçue. Les auteurs concluent que ce modèle a des implications claires pour les interventions visant à prévenir l'usage de cannabis :

> [Traduction] *« Dans l'échantillon provincial, l'usage par les pairs, les normes des pairs, la disponibilité, les préférences personnelles et les normes personnelles comptent pour 56 % de 57 % d'usage personnel prédit par le modèle. Les normes des pairs et la disponibilité passent par l'usage par les pairs, de sorte que les normes personnelles, les préférences personnelles et l'usage par les pairs sont des cibles importantes pour les interventions. Parmi ces variables, les préférences personnelles et l'usage personnel sont celles qui contribuent le plus à la prédiction de l'usage personnel, comptant ensemble pour 48,8 % de la variance. Il est intéressant de noter qu'une partie importante de la disponibilité est prédite par l'usage parental, suggérant que l'usage de cannabis ou de haschich chez les pairs proviendrait de source parentale. Il s'agit là d'une cible pour les stratégies d'intervention. Le modèle suggère que les sources d'influence sur les variables cibles devraient faire partie de toute stratégie d'intervention. »*[47]

Tenant compte des limites du modèle ainsi que de la différenciation entre les genres et les districts de santé de la province quant au poids relatif des variables explicatives, il faut se demander si ce type d'analyse reflète adéquatement les usages, incluant les premiers usages. De plus, au vu des tendances internationales d'usage d'une part, ainsi que des études sur les usagers d'autre part, on peut s'interroger sur les postulats de ce type de modèle mécanique basé sur une rationalité des acteurs.

Enfin, Aquatias et coll. ont réalisé une étude sur l'usage du cannabis dans les cités de la banlieue parisienne.[48] L'intérêt de cette étude tient à la distinction fine que les auteurs font entre les formes d'usage du cannabis sur le double registre des caractéristiques des usagers d'une part et du discours idéologique d'autre part. Les auteurs montrent à la fois qu'il existe des usages durs d'une drogue douce et que les usages des dasses moyennes, associés le plus souvent dans l'imaginaire collectif aux formes d'usage convivial, en groupe et intégrés, tandis que ceux des jeunes des banlieues sont associés à l'excès et à la dérégulation, ne correspondent pas à la réalité des faits. Les uns comme les autres, en fonction des facteurs de leur environnement, développeront des usages régulés aussi bien que dérégulés.

L'étude révèle en effet qu'à côté de l'indétermination sociale reliés aux conditions d'existence dans la cité et de l'intégration professionnelle, des facteurs relatifs aux pressions du milieu de vie et à la capacité de conserver ou non une certaine autonomie par rapport aux sociabilités locales jouent un rôle important dans la détermination des modes et formes d'usage.

---

47 *Ibid.*, page 15.

48 Aquatias, S., (1999) « Usages du cannabis et situations sociales. Réflexion sur les conditions sociales des différentes consommations possibles de cannabis. » in Faugeron, C. (éd.) *Les drogues en France.* Paris : Georg. Pour l'étude originale : Aquatias. S. et coll. (1997) *L'usage dur des drogues douces, recherche sur la consommation de cannabis dans la banlieue parisienne.* Paris : OFDT.

« Nous avons essayé de comprendre ce qui fondait ces différents usages et noté combien l'indéterminations sociale – l'absence de valorisation sociale et de ressources monétaires suffisantes pour acquérir une relative autonomie – qui touche ces jeunes joue sur leurs parcours de fumeurs de cannabis.
Pourtant, dans de même situations de faible accès au marché du travail et aux ressources, certains fument sans excès, d'autres pas du tout et d'autres consomment de façon outrancière. De même, parmi ceux qui travaillent, certains consomment de manière conséquente et avec régularité du cannabis à fort taux de principe actif et d'autres ont des usages régulés et relativement faibles.
L'indétermination sociale est bien sûr un facteur explicatif des usages les plus importants, de même que l'intégration professionnelle apparaît bien comme un facteur de régulation des pratiques. Mais ces deux facteurs, chacun étant le versant de l'autre, ne constituent que le contexte global des comportements de consommation prolongée et intensive du cannabis.
(...)
Parmi les personnes en situation d'indétermination sociale, celles qui consomment de manière importante et prolongée sont aussi celles qui, dans la cité, sont soumises aux plus fortes tensions sociales, que ce soit des problèmes de réputation, des suivis judiciaires, des problèmes familiaux... (...).
Au contraire, ceux qui régulent leurs consommations sont ceux qui sont à la fois bien intégrés à la vie de la cité et qui ont réussi à préserver une certaine autonomie par rapport aux sociabilités locales. »[49]

L'étude propose une grille de lecture[50] des usages que nous reproduisons ici d'autant plus qu'elle nous inspirera pour notre propre classification des usagers.

	Usages régulés solitaires	Usages régulés en groupe	Usages solitaires dérégulés	Usages dérégulés en groupe
Consommation forte	Après le travail	Ennui	Problèmes personnels	Festivités, vacances
Consommation moyenne ou faible	Avant le travail Après le travail	Consommation courante de soirée Ennui		

Notons finalement que l'étude distingue entre quatre types de consommation :

- Consommation ponctuelle qui va de l'initiation aux usages récréatifs ;
- Consommation quotidienne modérée : de 3 à 5 joints par jour soit environ un gramme ;
- Consommation quotidienne conséquente (ou forte) : 5 à 6 joints par jour, soit entre 0,9 et 1,2 grammes ;
- Consommation quotidienne intensive : plus de 1,2 gramme par jour.

[49] Aquatias, S. (1999) *op. cit.*, pages 48-49.
[50] *Ibid.*, page 45.

Éléments de synthèse

Nous retenons principalement de l'analyse des histoires de vie des consommateurs et de leurs « trajectoires » que pour cette proportion variant entre 15 % et 20 % des expérimentateurs qui s'installeront dans une consommation régulière, les modalités et formes de cette « carrière » d'usager sont effectivement très variables mais que, pour une proportion importante de ces usagers au long cours, la consommation est intégrée à la vie sociale et personnelle.

Par ailleurs, et contrairement à ce que laissent penser un certain nombre de travaux de recherche, la consommation de cannabis n'est pas déterminée par une série de caractéristiques uniquement individuelles ou d'ordre psychologique, mais ni non plus uniquement d'ordre environnemental. Quel que soit le milieu d'appartenance, des circonstances qui demeurent pour partie ponctuelles et propres à l'histoire de chacun mènent parfois à des usages dérégulés, caractérisés notamment par une consommation intensive et en solitaire. Cette installation dans des usages dérégulés semble la plupart du temps temporaire mais nous n'avons pas croisé d'étude qui permettrait de conclure là dessus.

D'autre part, nous observons aussi que les attitudes sociales envers le cannabis ainsi que les caractéristiques du marché du cannabis semblent avoir peu d'impact sur les tendances de consommation.

Enfin, et surtout, nous retenons que l'installation dans une trajectoire d'usage régulier ne signifie pas nécessairement usage à problème. En même temps, il est vraisemblable qu'une initiation précoce et une installation hâtive dans une consommation régulière peuvent être des facteurs de risque vers une situation de consommation à problème. Pour le dire autrement, et ce sera important pour les choix de politiques publiques et d'interventions, l'âge précoce à l'initiation (moins de 16 ans) et l'installation hâtive dans une consommation quotidienne (moins de 20 ans) sont des marqueurs qui devraient servir au dépistage et à la prévention des consommations abusives. Nous y reviendrons au chapitre 7.

UNE ESCALADE VERS D'AUTRES DROGUES ?

La question de l'escalade (ou de l'introduction) occupe une place importante dans les débats sur la marijuana. L'on craint en effet que la consommation de cannabis ne mène vers la consommation d'autres drogues, notamment les drogues dites dures telles l'héroïne ou la cocaïne.

> *« La conséquence logique est que la hausse de la consommation de drogues entraînera une augmentation du nombre de personnes qui en subiront les conséquences. On pense que le cannabis est la drogue avec laquelle la plupart des jeunes s'initient à la consommation d'autres drogues. (...) Le concept de passerelle existe depuis longtemps et même si l'on ne possède aucune preuve concluante, le National Institute on Drug Abuse a signalé que d'après les résultats de recherches neurotoxicologiques la marijuana pourrait altérer le cerveau au point d'accroître la vulnérabilité à d'autres drogues.*
> *De nombreuses personnes estiment que la consommation de cannabis est un point de départ pour ceux et celles qui cherchent à accentuer les effets psychotropes d'une drogue. »* [51]

Il convient d'abord de clarifier les termes. La version de l'escalade (*stepping stone* en anglais) soutient que la consommation de cannabis mène inexorablement vers la consommation d'autres drogues. Dans cette version, la consommation de cannabis entraînerait des modifications neurophysiologiques, affectant notamment le système dopaminergique (autrement appelé le système de récompense) créant ainsi le besoin de passer à la consommation d'autres drogues. Cette théorie a été amplement rejetée par la recherche. C'est la conclusion que nous partageons de plusieurs organismes internationaux de recherche sur les drogues, dont l'organisme britannique *DrugScope* :

> [Traduction] *« La théorie de l'escalade s'avère intenable et ne repose sur aucune preuve concrète. La "preuve" que les usagers d'héroïne ont souvent commencé par fumer du cannabis n'est pas surprenante et ne réussit pas à démontrer pourquoi la très grande majorité des usagers de cannabis ne progressent jamais vers des drogues comme le crack ou l'héroïne. La théorie de l'escalade (que le public confond souvent avec la théorie de la porte d'entrée) a été rejetée par la recherche scientifique. La notion que le cannabis "causerait" l'usage de drogues nuisibles a été et devrait être rejetée entièrement. »* [52]

La théorie de la porte d'entrée (*gateway*) suggère que les trajectoires des usagers les amènent à faire face à des choix lorsqu'ils entrent dans une trajectoire de consommation et que l'un de ces choix sera d'utiliser ou non d'autres drogues. Selon cette version, certains facteurs tels une initiation précoce ainsi qu'une consommation

---

51 M. J. Boyd, président du Comité sur la toxicomanie et sous-chef du Service de police de Toronto, Association canadienne des chefs de police, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, fascicule 14, page 75.

52 DrugScope (2001) *Evidence to Home Affairs Committee Inquiry into Drug Policy*. Disponible en ligne à l'adresse : http://www.drugscope.org.uk/druginfo/evidence-select/evidence.htm

plus régulière et plus intensive renforceront cette possibilité. Par ailleurs, ces facteurs eux-mêmes, et notamment une initiation précoce au cannabis, sont reliés à des facteurs antérieurs, tenant du milieu familial et des conditions sociales d'existence, qui prédisposent les jeunes plus vulnérables à cette initiation précoce et à l'installation plus rapide d'une consommation régulière et intensive.

> [Traduction] *« Selon cette explication, le lien entre l'usage de cannabis et d'autres drogues reflète le fait qu'un certain nombre de facteurs de risques et de trajectoires de vie prédisposent les jeunes à utiliser du cannabis et que ces mêmes facteurs se superposent avec des trajectoires qui les prédisposent à utiliser d'autres drogues. »* [53]

En plus de ces facteurs prédisposant certains jeunes à une consommation plus intensive de substances psychoactives – dont l'alcool et le tabac en premier lieu – les conditions sociologiques dans lesquelles les usagers peuvent se procurer du cannabis font en sorte qu'ils sont en contact avec un milieu au moins marginal sinon criminalisé. Les revendeurs sont souvent les mêmes personnes qui vendent aussi héroïne, crack, amphétamines, cocaïne, ou ecstasy de sorte que les probabilités que le jeune usager de cannabis, déjà plus vulnérable par les facteurs de sa trajectoire personnelle, sera plus facilement en contact avec ces autres substances. Ajoutons aussi que grossistes et revendeurs «coupent » ou même mélangent les produits : on nous a dit à certaines occasions que l'ecstasy par exemple pouvait contenir bien autre chose que du MDMA.

De plus, s'il est vrai que la consommation de substances telles l'héroïne ou la cocaïne passe presque obligatoirement par la consommation préalable de marijuana, elle passe aussi par la consommation d'autres substances, notamment la nicotine et l'alcool qui seraient davantage les portes d'entrée d'une trajectoire d'usager que le cannabis.

Si l'on revient aux tendances d'usage des drogues dans la population, alors que plus de 30 % ont une expérience de consommation de cannabis, moins de 4% ont consommé de la cocaïne et moins de 1 % de l'héroïne.

Par ailleurs, il est vrai que les usagers réguliers et intensifs sont plus susceptibles que les occasionnels de consommer d'autres substances. L'étude de Cohen et Kaal[54] discutée à la section précédente démontre par exemple que plus de 90 % des usagers de cannabis au long cours ont aussi consommé du tabac et de l'alcool au cours de leur vie, mais surtout que 48 % à Amsterdam et 73 % à San Francisco ont consommé de la cocaïne au moins une fois au cours de leur vie, et 37 % à Amsterdam, 77 % à San Francisco et 47 % à Bremen ont consommé des hallucinogènes au moins une fois. Néanmoins aucun des usagers réguliers de cannabis ne faisait un usage régulier d'autres substances. Les auteurs indiquent aussi que la séquence la plus fréquente est l'alcool (vers 14 ans), le tabac (vers 15 ans), le cannabis (vers 17 ans), suivi des autres drogues au début de la vingtaine.

---

[53] *Ibid.*

[54] Cohen et Kaal, *op. cit.*, pages 92-93.

Nous sommes d'avis que les données disponibles démontrent que **ce n'est pas le cannabis en soi qui mène vers la consommation d'autres drogues** mais la combinaison des facteurs suivants :

- Des facteurs reliés à l'histoire personnelle et familiale qui prédisposent à une entrée précoce sur une trajectoire de consommation de substances psychoactives commençant avec l'alcool ;
- Une initiation précoce au cannabis, plus précoce que la moyenne des expérimentateurs, et une installation plus rapide dans une trajectoire de consommation régulière ;
- La fréquentation d'un milieu marginal ou déviant ;
- La disponibilité des diverses substances chez les mêmes revendeurs.

CANNABIS, VIOLENCE ET CRIMINALITÉ

Il est évident qu'il existe une certaine association entre les substances psychoactives et la criminalité. Il est tout aussi évident que ce lien est beaucoup plus complexe qu'on ne le dit parfois, comme l'a souligné le professeur Brochu lors de son témoignage devant le Comité.

> *« Seulement à mon bureau de l'Université de Montréal, 2 973 études tentent d'établir un lien entre les substances psychoactives et la criminalité. La majorité de ces études viennent des États-Unis ou de pays anglophones, et cela a pour effet de teinter quelque peu la vision des choses parce qu'on sait que nos voisins américains ont opté pour une approche répressive dans le domaine des drogues illicites. Ce qui ressort de l'ensemble de ces études, c'est la complexité du lien entre la drogue et le crime. »*[55]

Depuis son témoignage, le professeur Brochu a rendu publique l'étude dont il a fait mention au Comité.[56]

On peut examiner la relation drogue – criminalité sous au moins trois angles : les effets de la substance elle-même, les effets du coût de la substance, et l'appartenance de la drogue au monde illicite.

Une proportion importante des contrevenants a des problèmes reliés à l'abus de substances psychoactives, l'alcool au premier plan. De fait, l'étude conclut que l'alcool est la substance la plus fréquemment associée aux délits de violence ; dans le cas des délits contre la propriété, ce sont les drogues illicites qui dominent. Le cannabis venait

---

[55] Professeur Serge Brochu, Université de Montréal, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 10 décembre 2001, fascicule 12, page 18.

[56] Pernanen, K. et coll., (2002) *Proportions of crimes associated with alcohol and other drugs in Canada.* Ottawa : Centre canadien de lutte contre l'alcoolisme et les toxicomanies.

au troisième rang (3 à 6 % selon l'étude), loin derrière l'alcool (24 %) et la cocaïne (8 à 11 %).

Sur la seconde approche, les auteurs établissent qu'entre 17 % et 24 % des détenus ont commis une infraction pour se procurer l'argent nécessaire à l'achat de la substance de choix, la plupart du temps de la cocaïne.

Enfin, sur la troisième approche, le fait que les drogues illicites soient marginalisées fait en sorte d'exposer les usagers à un milieu déviant. Nous avons noté à la section précédente que, concernant le cannabis, le fait que les revendeurs puissent offrir de l'héroïne ou du crack en même temps que du cannabis peut favoriser une trajectoire de passerelle vers ces autres drogues. De la même manière, le fait que ces substances soient illégales peut contribuer à amener des personnes vers une trajectoire délinquante. De plus, le milieu du trafic de drogues est un milieu relativement violent où se commettent toute une série d'infractions. Enfin, le seul fait de vendre du cannabis constitue en soi une infraction pénale et l'on sait qu'un certain nombre de personnes sont incarcérées pour cette raison (du moins si la quantité est supérieure à 30 grammes).

Au total, le cannabis en soi ne mène pas à une trajectoire délinquante et c'est plutôt l'inverse qui pourra se produire : une personne s'inscrivant jeune dans une trajectoire de délinquance sera plus rapidement exposée aux drogues illicites et pourra expérimenter plus tôt et s'installer plus tôt dans une carrière de consommateur.

De plus, en raison même de ses effets psychoactifs relaxants et euphorisants et de ses effets moteurs sur le relâchement du tonus musculaire, le cannabis est peu propice à entraîner des actes de violence.

Les données des études sur les consommateurs à long terme confirment ce portrait d'ensemble sur la relation entre cannabis et criminalité. Ainsi, Cohen et Kaal ont observé que moins de 5 % de leurs répondants avaient commis des infractions pour obtenir du cannabis (menus larcins, vol à l'étalage, vols). L'infraction la plus fréquemment commise pour obtenir du cannabis était d'en vendre.

En somme, le Comité retient que le cannabis n'est pas une cause de violence ni de criminalité sauf dans de rares cas et à l'exception bien entendu de la conduite sous l'influence dont il sera question au chapitre 8.

CONCLUSIONS

Nous retenons de l'ensemble des informations sur les tendances, modes, contextes, trajectoires et conséquences sociales de l'usage de cannabis ce qui suit :

Conclusions du chapitre 6	
Sur les tendances d'usage	➢ **L'infrastructure de connaissance nationale sur les tendances et contextes d'usage est fondamentalement faible et doit être renforcée d'urgence.** ➢ **Les données épidémiologiques disponibles indiquent que près de 30 % de la population (12 à 64 ans) a une expérience vie du cannabis.** ➢ **Environ 10 % ont une prévalence au cours de l'année précédente.** ➢ **Jusqu'à 30 % des usagers de l'année dernière sont des usagers courants (au cours du mois).** ➢ **Environ 15 % des usages du dernier mois sont des usagers quotidiens.** ➢ **La consommation est la plus importante entre 16 et 24 ans.** ➢ **Chez les jeunes de niveau secondaire, la prévalence au cours de l'année est plus élevée, à environ 40 %.**
Sur les trajectoires	➢ **La prévalence de l'usage mensuel chez les jeunes est d'environ 30 %.** ➢ **La prévalence de l'usage quotidien chez les jeunes est d'environ 9 %.** ➢ **L'âge d'initiation est en moyenne à 15 ans.** ➢ **La plupart des expérimentateurs discontinuent l'usage.** ➢ **Les usagers réguliers ont généralement une initiation plus précoce.** ➢ **Les usagers à long terme ont le plus souvent une trajectoire de consommation en dents de scie.** ➢ **Les consommateurs réguliers à long terme connaissent leur période de consommation intense au début de la vingtaine.** ➢ **La plupart des usagers à long terme intègrent leur consommation à leurs activités familiales, sociales et professionnelles.**
Sur la passerelle	➢ **Le cannabis n'est pas, en soi, une cause de consommation d'autres drogues.** ➢ **La consommation de cannabis peut être une porte d'entrée en raison de l'illégalité qui met en contact avec d'autres substances.**

Sur la violence et la criminalité	➢ **Le cannabis n'est pas en soi une cause de délinquance et de criminalité.** ➢ **Les jeunes qui ont une trajectoire de consommation régulière et intensive ont souvent déjà une inscription dans une trajectoire déviante sinon délinquante** ➢ **Le cannabis n'est pas une cause de violence.**

CHAPITRE 7

LE CANNABIS : EFFETS ET CONSÉQUENCES

Le cannabis, nous l'avons vu au chapitre 5, agit sur le système nerveux central et sur des systèmes périphériques de diverses manières. Si la recherche a permis d'établir assez clairement le rôle de certaines des composantes du cannabis, et notamment du Δ^9THC qui en est le principal élément actif, l'on connaît moins le rôle des autres composants du cannabis. De même, la recherche, souvent menée sur des animaux en laboratoire ou de manière encore plus pointue sur des molécules extraites aux fins d'expérimentation, ne tient pas compte des conditions dans lesquelles la marijuana sera consommée par l'usager moyen. On a vu que, dans certains cas, les dosages utilisés aux fins d'expérimentation sur des animaux en laboratoire, notamment pour déterminer les effets chroniques de l'usage régulier, portent sur des doses inimaginables pour des humains, équivalant à 570 cigarettes de marijuana par jour. Puisque le contenu en THC est très variable selon les arrivages de cannabis sur le marché, puisque les consommateurs en font des usages diversifiés selon les lieux et les circonstances, et sachant aussi que des caractéristiques individuelles sont en interaction avec les effets réels du cannabis, la connaissance des effets en sera nécessairement affectée.

De manière encore plus technique, il convient de souligner qu'une association statistique – c'est-à-dire le fait que deux faits soient concomitants – ne signifie nullement relation de causalité. Pour que l'on puisse faire une inférence de causalité, il faut satisfaire à un certain nombre de prérequis méthodologiques : en plus de l'association statistique, l'on doit pouvoir écarter le hasard, repousser des hypothèses alternatives, et démontrer que le facteur causal précède bel et bien la conséquence imputée. Selon l'OMS :

> [Traduction] *« Des inférences causales peuvent être faites à partir de données de recherche en évaluant dans quelle mesure la « preuve » satisfait aux critères largement reconnus. Ceux-ci incluent la force de l'association, sa consistance, sa spécificité, la relation dose-réponse, la plausibilité biologique et la cohérence avec d'autres connaissances. Ces critères ne sont pas suffisants pour établir qu'une association est causale, mais plus on satisfait de critères, plus il est vraisemblable qu'il s'agit d'une association qui est causale.»* [1]

---

[1] World Health Organization (1997), *op. cit.*, page 3 ; voir aussi sur cette question : Hall, W. (1987) « A simplified logic of causal inference » *Australian and New Zealand Journal of Psychiatry*, 21, pages 507-513.

Par ailleurs, une tradition forte de philosophie de la connaissance scientifique soutient qu'on ne peut jamais prouver une hypothèse, tout au mieux peut-on la falsifier – c'est-à-dire rejeter – des hypothèses alternatives.[2]

Pour tenter de répondre à ces exigences de la causalité, les chercheurs ont élaboré des méthodes de recherche sophistiquées, prévoyant notamment la sélection aléatoire des sujets à l'étude, l'assignation aléatoire aux conditions expérimentales et aux conditions sans traitement expérimental (groupe de contrôle), l'utilisation de techniques du double aveugle et du placebo, et le contrôle fin de variables intervenantes qui peuvent représenter autant d'hypothèses alternatives que l'on essaie ainsi d'éliminer. C'est ainsi par exemple que l'on tente, la plupart du temps, de tester les médicaments qui sont mis sur le marché.

Pour la plupart des questions impliquant le comportement humain, a fortiori en société, l'on peut difficilement et rarement établir une telle relation de causalité pour la simple raison que l'on peut rarement satisfaire à chacune de ces exigences méthodologiques. Dans le cas qui nous occupe sur les effets de l'usage du cannabis, les contraintes méthodologiques sont particulièrement évidentes. On ne peut tirer un échantillon aléatoire des usagers de cannabis puisqu'on n'en connaît pas la population. Il faut donc recourir à des méthodes alternatives de sélection des sujets (volontaires par exemple). On peut difficilement faire fumer du cannabis à des personnes qui n'en auraient jamais consommé[3] sans risquer de contrevenir à certaines règles d'éthique voire aux dispositions légales. Et si l'on a recours à des fumeurs déjà expérimentés, il se produit nécessairement une contamination du groupe de contrôle. Le cannabis que l'on utilise en laboratoire peut être totalement différent de celui que consomment les usagers qui se le procurent sur la rue. Et les conditions de laboratoire contrôlé ne reproduisent certainement pas les modes d'usage du cannabis dont on sait qu'il est la plupart du temps une forme de rituel social. Quant aux études – et elles sont nombreuses – menées sur des échantillons d'animaux (singes, souris, rats...) – elles peuvent être intéressantes mais les possibilités de transposer leurs résultats aux humains sont limitées. Notons enfin que, la plupart des fumeurs de cannabis étant aussi des fumeurs de tabac et des consommateurs d'alcool, il est difficile de dissocier les effets des uns et des autres.

Cela n'empêche pas évidemment les chercheurs de mener des études, et c'est d'ailleurs nécessaire. Par contre, cela oblige les chercheurs à la plus grande prudence dans l'interprétation de leurs résultats, notamment quant à la capacité de généraliser à l'ensemble des usagers de marijuana et de tirer des inférences causales. Prudence que l'on ne retrouve pas toujours, tant s'en faut, comme ce chapitre le montrera à l'envi.

---

[2] Là dessus, les travaux de Karl Popper, notamment : (1978) *Logique de la découverte scientifique* Paris : Payot et (1985) *La connaissance objective*. Bruxelles : Complexe.

[3] Il est même un peu ironique que le National Institute on Drug Abuse (NIDA) aux USA finance des études qui comportent le fait de faire fumer des gens alors que l'Institut croit que le cannabis est une drogue d'entrée : voir par exemple l'étude de Haney, M. et coll. (1999) « Abstinence symptoms following smoked marijuana in humans » *Psychopharmacology*. 141, pages 395-404.

Notons enfin la distinction entre effets et conséquences. Fumer du cannabis a des effets immédiats, certains physiologiques d'autres psychosociaux, que nous devons décrire. Mais fumer du cannabis, surtout de manière répétée, peut aussi avoir des conséquences, certaines proximales – par exemple la capacité à mener certaines tâches ou la capacité à conduire un véhicule – et d'autres plus distales – par exemple si le fait de fumer du cannabis entraîne des risques plus élevés de cancer du poumon ou s'il affecte la mémoire de manière durable.

Nous sommes conscients de ce que ces distinctions peuvent avoir d'arbitraire dans la mesure où l'humain est un tout, un organisme intégré dans son environnement affectif et social et dans son écosystème. Les effets physiologiques, psychologiques et sociaux sont en interaction les uns avec les autres, ils s'interpénètrent, s'influencent, et agissent ensemble plutôt que séparément. D'une certaine manière, ces distinctions demeurent le reflet de notre incompétence, du moins de notre incapacité, à penser les divers systèmes de l'humain ensemble, dans leur globalité. Cette même incompétence peut, pour partie aussi, expliquer les difficultés que nous avons à concevoir une politique sur les drogues. D'autres après nous arriveront, souhaitons-le, à produire une approche intégrée, holistique. Pour l'heure, nous en sommes réduits à utiliser les moyens à notre disposition, ceux de la connaissance fragmentée.

Une dernière note préliminaire. Nous avons eu la préoccupation constante de rester rigoureux. Pour autant, nos ressources ne nous permettaient pas d'être exhaustifs et d'examiner une à une les études sur l'ensemble de ces questions. Au total, on sait qu'environ dix mille études ont été publiées au cours des quarante dernières années sur le cannabis ! Certes, comme le souligne Nelson, « (Traduction) *Bien que le volume total de littérature sur ce sujet soit tout simplement immense au premier abord, l'examen révèle rapidement que beaucoup d'études sont répétitives et que les auteurs renvoient constamment à un petit nombre de textes.* »[4] Ceci étant, nous ne pouvions faire l'économie de l'examen d'un certain nombre de ces études. C'est pourquoi nous avons commandé la préparation d'un rapport de synthèse[5] et avons aussi examiné des synthèses de la littérature scientifique qui ont été préparées ces dernières années.[6]

Ce chapitre se divise en cinq sections. La première rassemble un ensemble d'affirmations sur les effets présumés de la marijuana que le Comité a entendues ou qui ont été portées à sa connaissance par ses recherches. Les trois sections suivantes examinent d'abord les effets aigus du cannabis, puis tour à tour ses conséquences physiologiques et neurologiques, psychologiques, et sociales. En raison de son importance et de la place centrale qu'elle occupe dans les préoccupations sociales et

---

[4] Nelson, P.L. (1993) «A critical review of the research literature concerning some biological and psychological effects of cannabis » in Advisory Committee on Illicit Drugs (eds.) *Cannabis and the law in Queensland : A discussion paper.* Brisbane : Criminal Justice Commission of Queensland.

[5] Wheelock, B. (2002) *op. cit.*

[6] Notamment les rapports déjà mentionnés de l'INSERM (2001), *op. cit.* et de la Conférence scientifique internationale sur le cannabis (2002) ; ainsi que le rapport du National Institute of Medicine aux USA et le livre édité par le professeur Kalant, l'un de nos témoins.

politiques, nous examinons ensuite spécifiquement la question de la dépendance qui peut découler d'une consommation prolongée de cannabis.

EFFETS ET CONSÉQUENCES DU CANNABIS : CE QU'ON NOUS A DIT

Au cours de nos audiences, de nombreux témoins nous ont fait part de leurs connaissances sur les effets du cannabis. Certaines de ces connaissances provenaient de leurs propres travaux de recherche. D'autres provenaient de leurs expériences professionnelles. D'autres enfin étaient soit des interprétations de la littérature scientifique, soit des anecdotes. Dans cette section, nous ne faisons pas de distinction entre les témoignages, nous n'en évaluons pas la validité. Nous voulons uniquement faire ressortir la richesse en même temps que la complexité de ce qui nous a été dit.

> *« Le premier message est que les drogues, y compris le cannabis, sont nocives. (...) De nombreuses conceptions erronées circulent au sujet de la consommation de cannabis. Une forte consommation a incontestablement des conséquences néfastes sur la santé. Ces conséquences se traduisent la plupart du temps par des troubles respiratoires, un manque de coordination physique, des problèmes de développement pendant la grossesse et après la naissance, des troubles de mémoire et des troubles cognitifs, sans compter les effets psychiques. (...). »*[7]

> *« D'une façon générale, la marijuana (cannabis) et ses dérivés sont décrits comme des drogues douces pour les différencier des préjudices connus associés aux autres drogues illicites. Cette approche, en dépit de ses dangers, fonctionne et contribue à l'incompréhension, à la désinformation et à l'accroissement de la tolérance à l'égard de sa consommation. La marijuana est une drogue puissante aux effets variés. Ses consommateurs sont sujets à divers problèmes de santé comme les lésions respiratoires, la réduction de la coordination physique, les préjudices à la grossesse et au développement postnatal, la réduction de la mémoire et des fonctions cognitives et divers effets psychiatriques. La consommation de marijuana est associée à la médiocrité au travail et en classe de même qu'aux problèmes d'apprentissage chez les jeunes. Elle est internationalement connue comme drogue d'introduction. Ses facteurs de risque d'assuétude sont comparables à ceux des autres formes de toxicomanie. (...) La communauté internationale en est venue à un consensus visant à placer la marijuana, tout comme les autres intoxicants, sous contrôle. Cette décision repose sur des preuves de sa nocivité pour la santé humaine et de son potentiel de création de dépendance. »*[8]

---

[7] Témoignage de Michael J. Boyd, président du Comité sur la toxicomanie et Directeur adjoint du Service de police de Toronto, pour l'Association canadienne des Chefs de police, Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, fascicule no 14, page 74.

[8] M. Dale Orban, sergent-détective, Service de police de Regina, pour l'Association canadienne des policiers et policières, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, lundi 28 mai 2001, fascicule 3, page 47. Notons immédiatement que la dernière affirmation est totalement fausse comme nous le verrons aux chapitres 19 et 12 sur les conventions internationales et la législation canadienne qui ont placé le

« J'aimerais brièvement passer en revue deux des effets dont la nocivité, je crois, a été relativement bien établie, et quelques autres effets qui font l'objet d'importantes théories. (...) L'effet de la marijuana qui est, de loin, le plus constant et le plus net est la perturbation de la mémoire à court terme. C'est la mémoire que l'on qualifie généralement de « mémoire de travail ». Elle touche le mécanisme du cerveau qui est responsable de la préservation, à court terme, de l'information nécessaire à l'exécution de tâches complexes qui exigent planification, compréhension et raisonnement. La perturbation relativement grave de la mémoire de travail peut contribuer à expliquer pourquoi les sujets intoxiqués à la marijuana éprouvent de la difficulté à maintenir une chaîne d'idées ou à suivre une conversation. (...) Manifestement c'est un problème pour quelqu'un qui va à l'école drogué. (...) Il est de plus en plus clair que le cannabis est une drogue dont les consommateurs réguliers deviennent dépendants, et que cela a des effets nocifs sur un nombre de gens. »[9]

« Il a été démontré que la marijuana est associée à la conduite dangereuse et aux accidents. Les preuves suggèrent que la marijuana contribuerait à un nombre significatif de blessures et de mortalité routière au Canada. Il a été démontré qu'elle a des effets négatifs sur le développement académique et social de certains adolescents. L'usage chronique peut être associé aux maladies pulmonaires telles la bronchite, l'emphysème et le cancer. Certaines personnes peuvent développer une psychose, et d'autres symptômes tels l'anxiété, la dépression et la panique se produisent. On sait que la marijuana est addictive. Bien que variable, le taux d'addiction varie entre 5 et 10 %. J'aimerais souligner que la toxicomanie est une maladie et que la marijuana peut mener à la toxicomanie chez certaines personnes génétiquement prédisposées. »[10]

« D'après les témoignages, 95 % des personnes qui fument de la marijuana au Canada en font un usage faible, occasionnel et modéré. Leur consommation n'a pas d'incidence d'ordre sanitaire pour autant qu'il s'agisse d'adultes en santé. Les 5 % qui restent sont des usagers chroniques, des personnes qui fument une cigarette de marijuana ou plus par jour. S'ils persistent, ils finiront par contracter une bronchite chronique attribuable au simple fait de fumer. La même chose leur arriverait s'ils fumaient l'herbe de leur pelouse. Du simple fait qu'ils inhalent la fumée résultant de la combustion d'un matériau, ils causent des dommages à leurs voies respiratoires. Il y a trois grands groupes de personnes vulnérables : les femmes enceintes, et à ce moment-là, c'est à notre avis une question qui doit se régler entre la femme et son médecin ; les handicapés mentaux, particulièrement les schizophrènes paranoïaques (...) et, chose plus importante, les jeunes n'ayant pas atteint la maturité. La consommation de marijuana chez les jeunes – particulièrement sur une base régulière – semble nuire à leurs études et au processus de

---

cannabis sur les listes de drogues contrôlées dès 1923, sans savoir à cette époque aucune connaissance de ses effets physiques ou psychologiques, et pour de tout autres raisons, lorsque raisons il y avait.

[9] Dr Mark Zoccolillo, professeur de psychiatrie et professeur adjoint de pédiatrie, Université McGill et Hôpital pour enfants de Montréal, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, deuxième session de la trente-sixième législature, 16 octobre 2000, fascicule no 1, page 77.

[10] Dr Bill Campbell, président, Société médicale canadienne sur l'addiction, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 11 mars 2002, fascicule no 14, page 56.

maturation. Comme c'est le cas de toutes les substances intoxicantes, il est recommandé de ne pas en consommer avant d'avoir atteint la maturité. » [11]

« Des études récentes menées par le Center for Susbtance Abuse Prevention des États-Unis font ressortir certains des risques liés à la consommation du cannabis. Nous savons déjà que la consommation du cannabis a des effets nocifs sur de nombreux systèmes dont le système respiratoire, le système moteur, la mémoire et le système immunitaire, et qu'elle crée la dépendance ainsi que la tension. De nombreuses études démontrent maintenant l'existence d'un syndrome de sevrage chez les consommateurs chroniques de cannabis qui cessent de consommer cette drogue. (...) Des recherches indiquent que la consommation de cannabis nuit au développement du fœtus. (...) Permettez-moi maintenant de vous parler d'un trouble de l'attention qui prend la forme d'une déficience du balayage visuel et des fonctions connexes. Le balayage visuel se développe en particulier au début de l'adolescence et l'on craint que la consommation de cannabis puisse déclencher une déficience à cet égard. » [12]

« Un certain nombre d'effets négatifs ont été suscités en laboratoire ou observés auprès des consommateurs à long terme (...). La consommation de cannabis présente évidemment des risques et des conséquences négatives pour la santé, mais la majorité de ces risques n'apparaissent que dans des circonstances bien particulières. Ils sont associés à une consommation constante et fréquente et doivent donc être compris dan ce contexte. On s'accorde pour dire que le symptôme dit de dépendance ou de sevrage peut apparaître chez les grands consommateurs chroniques, mais il est tout à fait limité à ce petit groupe. (...) Le rapport précurseur de Hall et de ses collègues australiens (...) ont conclu que l'on peut atténuer sensiblement les principaux risques de la consommation du cannabis en évitant de conduire sous l'effet de cette substance, en évitant une utilisation chronique et quotidienne et en évitant d'inhaler profondément la fumée. Voilà les principaux facteurs qui permettent d'éviter la plupart des dangers et des risques liés à la consommation. » [13]

« Quoi qu'il en soit, nous parlons de dérivés de plantes qui contiennent un certain nombre d'alcaloïdes psychoactifs. Les effets psychoactifs comprennent principalement une euphorie légère et une altération de la notion du temps. Une désorientation et des crises de panique peuvent aussi se produire. On dit aussi que l'appréciation de la musique et de l'art est meilleure à l'instar de l'appétit. Ce dernier élément semble important pour l'un des prétendus bienfaits, à savoir l'atténuation des effets de la cachexie liée au sida et de la nausée qui accompagne les traitements de chimiothérapie. (...) Parce que le cannabis est habituellement fumé, il comporte les mêmes effets aigus et chroniques que le tabac, dont l'irritation des voies respiratoires, la toux, et, probablement en raison d'une utilisation à long terme, la bronchite, la bronchopneumonie chronique obstructive et le cancer du poumon et du pharynx. La consommation de cannabis affaiblit le système immunitaire, mais son incidence sur la santé est probablement mineure. (...) Par ailleurs des études menées chez les animaux ont révélé des répercussions sur le système de

---

[11] M. John Conroy, avocat, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 11 mars 2002, fascicule no 14, page 11.

[12] Dr Colin Mangham, Directeur, Prevention Source BC., témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 17 septembre 2001, fascicule no 6, page 71.

[13] Dr Benedikt Fischer, professeur, département des sciences de la santé publique, Université de Toronto, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 17 septembre 2001, fascicule no 6, page 9.

reproduction. (...) Ces résultats sont bien sûr pertinents pour l'humain, mais des études menées chez ces derniers n'ont pas encore démontré une incidence négative mesurable, à part des répercussions sur le comportement et le développement des enfants nés de mères qui ont fumé du cannabis durant la grossesse. (...) Beaucoup de documents existent au sujet de l'incidence du cannabis sur la cognition. La mémoire à court terme est touchée et l'utilisation à long terme peut mener à un mauvais fonctionnement chronique et mesurable de la fonction cognitive, bien que cela puisse résulter d'une intoxication chronique persistante plutôt que d'une détérioration de la substance du cerveau. Le cannabis a aussi une incidence négative sur les habiletés psychomotrices. Il est d'ailleurs contre-indiqué de conduire ou de faire fonctionner de l'équipement lourd sous l'effet du cannabis. Encore une fois, contrairement à l'alcool, le cannabis a tendance à ralentir les conducteurs au lieu de les faire accélérer. De même, il est rare que les fumeurs de cannabis soient impliqués dans des cas d'agression et de violence physique. Le cannabis peut déclencher des symptômes de la schizophrénie chez les personnes atteintes de cette maladie ou du trouble schizoprhéniforme. La documentation fait aussi état de crises de panique et dysphorie. On avait prétendu que le cannabis provoquait l'apparition du syndrome amotivationnel, mais les chercheurs ont rejeté cette idée au cours des dernières années. (...) Des préoccupations ont été soulevées avec raison à propos de la consommation de cannabis sur le développement des adolescents. Il s'agit d'une question importante, d'autant plus que l'utilisation est la plus élevée à la fin de l'adolescence. Le risque de décrochage scolaire, l'instabilité sur le plan de l'emploi et le passage à des drogues plus dures sont toutes des conséquences négatives qui ont été associées à la prise de cannabis. On ne s'entend pas encore toutefois sur la mesure dans laquelle ces liens constituent des causes. D'autres hypothèses ont été posées, à savoir que la consommation de cannabis chez les adolescents, comme la consommation d'alcool, le début précoce des relations sexuelles ou le tabagisme, est en fait un repère pour d'autres risques ou conditions sociales défavorables. (...) Tous les chercheurs s'entendent toutefois pour affirmer que l'effet ressenti en consommant du cannabis diminue les habiletés scolaires. Des études récentes semblent démontrer une baisse mesurable, quoique réversible, du quotient intellectuel liée à la consommation assidue de grandes quantités de cannabis, et que la participation à des activités illégales comporte des risques considérables, surtout peut-être pour les jeunes dont le lien avec l'école est faible. »[14]

« Je m'attarderai d'abord sur les effets aigus puis sur les effets chroniques. Les effets aigus sont ceux consécutifs à l'action d'une dose unique. Dans le système nerveux central, cela inclut une période de plusieurs heures pendant laquelle le sujet est atteint de stupeur chimique. On compte, parmi les effets secondaires, une baisse du niveau d'éveil et la somnolence, qui se conjugue à la somnolence provoquée par l'alcool et autres dépresseurs du système nerveux. Parmi les autres effets secondaires, on note une altération de la mémoire à court terme, un ralentissement des réactions, une baisse de l'exactitude lors des tests et une attention moins sélective. (...) Une faible dose produit généralement les effets qui font que les gens prennent plaisir à fumer de la marijuana. Il s'agit d'une euphorie douce, de détente, de sociabilité accrue et d'une baisse non spécifique de l'anxiété. Toutefois, une dose élevée entraîne la mauvaise humeur, l'anxiété et la dépression. L'anxiété accrue peut aboutir à la panique ou même à une psychose toxique aiguë qui, heureusement, est de très courte durée et disparaît lorsque l'effet de la drogue se dissipe. Une dose élevée cause une altération de la coordination motrice, des mouvements mal assurés et une baisse du tonus musculaire, ce qui peut être utile du point de vue thérapeutique. (...) À petites doses, la perception est améliorée. Cela fait partie du plaisir. À fortes doses, la même action produit une

---

[14] Dr Perry Kendall, agent de santé de la province de la Colombie-Britannique, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 17 septembre 2001, fascicule no 6, pages 33-33.

distorsion sensorielle, des hallucinations et la psychose toxique aiguë dont j'ai parlé. (...) Elle n'a pas d'effets graves sur le système cardio-vasculaire. (...) Pour ce qui est des effets chroniques, dans le système nerveux central, on constate des troubles de la mémoire, une pensée floue, la facilité verbale atténuée ainsi que des déficits d'apprentissage chez les grands consommateurs, les consommateurs chroniques. J'insiste sur le mot « grand » parce que le consommateur convivial ne présente pas, dans l'ensemble, de troubles importants, pas plus que le buveur convivial. (...) Heureusement, les effets sur les facultés cognitives ont tendance à disparaître si le grand consommateur arrête, pour quelque raison que ce soit. Tant que la consommation dure, on observe une intoxication chronique, de l'apathie, de la confusion, de l'hébétude, de la dépression et parfois de la paranoïa. (...) La dépendance au cannabis, telle que définie selon les critères diagnostics conventionnels de dépendance que l'on retrouve dans la dernière édition de la publication de l'American Psychiatric Association ou son équivalent à l'Organisation mondiale de la santé, est largement attestée chez les grands consommateurs, les consommateurs réguliers. De nombreuses études démontrent à présent qu'un pourcentage important de consommateurs réguliers sont dépendants. Dans certaines études australiennes de grands consommateurs de longue durée, principalement des consommateurs quotidiens pendant des périodes de 15, 17 et 20 ans, 60 % d'entre eux répondent aux critères diagnostiques de dépendance. (...) On a constaté une tolérance. Pour l'essentiel, ce n'est pas un effet très grave et le syndrome de sevrage physique n'est pas sévère. Néanmoins, il existe, ce qui indique une dépendance physique outre la dépendance psychologique. » [15]

« À long terme, les effets chroniques du cannabis vont entraîner essentiellement les symptômes suivants : des déficits de la mémoire, de l'attention et de la concentration, un syndrome d'amotivation qui va se caractériser par une passivité et une diminution de l'initiative, des risques accrus de maladies respiratoires, en particulier l'asthme, la bronchite et l'emphysème, et des risques accrus de cancer. (...) On peut ajouter des troubles hormonaux qui peuvent entraîner une diminution de la fertilité chez l'homme et chez la femme. Également chez l'homme, cela peut entraîner le développement des seins qui peut être très désagréable sur le plan esthétique. (...) Finalement, cela peut aussi entraîner, à la longue, une diminution de la résistance aux infections. » [16]

Comme on le voit, les avis se recoupent parfois, et divergent souvent. Ils se recoupent au moins sur la nature des conséquences qui peuvent préoccuper. On a vu tour à tour des effets d'ordre physiologique (risques de cancer, impacts sur la reproduction ou sur le système immunitaire, détérioration des cellules du cerveau), des effets d'ordre psychologique (syndrome amotivationnel, risques de psychose, altération des fonctions cognitives et spécifiquement de la mémoire), et des impacts d'ordre social (sur la famille et le travail, ainsi que sur la conduite de véhicules ou l'opération de machinerie). Ils se contredisent surtout sur la portée des conclusions que l'on peut tirer de la connaissance. Dans quelle mesure, en effet, peut-on généraliser les effets que l'on observe à partir d'échantillons souvent petits, rarement aléatoires de sujets ? Dans

---

[15] Dr Harold Kalant, professeur émérite à l'Université de Toronto, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 11 juin 2001, fascicule no 4, pages 74-76.

[16] Dr Mohamed ben Amar, professeur de pharmacologie et de toxicologie, Université de Montréal, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 11 juin 2001, fascicule no 4, pages 9-10.

quelle mesure encore généraliser les données sur des consommateurs chroniques qui ne représentent – comme l'a montré le chapitre précédent – qu'une faible proportion des usagers du cannabis ? Dans quelle mesure surtout ces données permettent-elles d'établir des relations causales ?

Le Comité constate aussi que la plupart des témoins ont mis l'accent sur les dimensions négatives, rarement sur les aspects positifs. Pourtant, si des personnes consomment des drogues généralement, du cannabis en particulier, ce n'est sûrement pas uniquement pour s'autodétruire ni parce que ces drogues n'auraient que des effets négatifs. Admettant les limites de toute comparaison entre substance, on peut néanmoins faire le parallèle avec l'alcool : la plupart d'entre nous connaissons le plaisir d'un verre de vin partagé avec des amis lors d'un bon repas, tout comme nous connaissons aussi les dangers de l'abus et de l'alcoolisme. Nous constatons aussi qu'il est difficile, même pour les chercheurs les plus chevronnés, de faire le tri des connaissances sans leur accorder une valence relativement aux orientations que devraient avoir les politiques publiques. Une même connaissance sera interprétée ici de manière négative, là de manière plus modérée, selon les préconceptions de l'interprète quant au « meilleur » choix d'une politique publique. Nous ne sommes pas à l'abri de ces biais. D'ailleurs, nous ne nions pas que nous avions des préconceptions, héritées de nos histoires personnelles, de nos lectures, des audiences aussi que nous avions menées en 1996 autour de l'étude de la législation canadienne sur les drogues. Parmi ces préconceptions qui ont, du moins au départ, orienté notre lecture des témoignages, nous pouvons noter :

- La conviction que le système actuel n'atteint pas ses objectifs, ne serait-ce qu'en raison de l'augmentation connue de la consommation de cannabis, notamment chez les jeunes ;
- Une préférence pour une approche plus consensuelle et plus en phase avec les attitudes des Canadiens ;
- Une préférence pour une approche de réduction des méfaits comme en témoignait le libellé de notre premier mandat ;
- Une tendance à distinguer entre drogues douces – dont le cannabis – et drogues dures (héroïne, cocaïne) ;
- Une certaine méconnaissance des effets spécifiques du cannabis, au regard des études toxicologiques et pharmacologiques menées au cours des dernières années.

Ceci étant, nous n'avons pas travaillé en vase clos. Non seulement avons-nous été accompagnés de notre équipe de recherche – sociologues, juristes, criminologues – tout au long de nos travaux, non seulement avons-nous aussi été sous la surveillance étroite en quelque sorte des témoins et plus largement du public ; mais surtout, d'autres que nous, dans d'autres pays, ont mené des études similaires au cours des dernières années dont nous nous sommes inspirés et auxquelles nous avons comparé nos propres conclusions.

EFFETS AIGUS DU CANNABIS

En toxicologie, on entend par effets aigus ceux qui se produisent immédiatement suite à la consommation et pendant que les effets psychoactifs se font sentir. Ces effets correspondent aussi à ce qu'on a appelé depuis déjà Moreau de Tours en 1845, l'ivresse cannabique.[17] Les effets « réels » – sur les systèmes biologiques – et les effets ressentis par les usagers peuvent varier selon un ensemble de facteurs tels l'expérience de l'usager avec le cannabis ou avec d'autres drogues (incluant le tabac), ses attentes, ou le contexte d'usage. De fait, «*les effets psychoactifs du cannabis, plus que toute autre substance, varient d'un sujet à l'autre et, pour un même sujet, d'une expérience à l'autre.* »[18] De plus, en l'absence d'une mesure fiable du contenu de THC dans le plasma sanguin, il est difficile de relier la durée et la force des effets à diverses préparations de cannabis, notamment en raison de variations dans la composition de la substance et la biodisponibilité du THC. Il est encore plus difficile d'attribuer des effets relativement rares (par exemple l'apparition de symptômes psychotiques) dans la mesure où l'on peut difficilement décider si la co-occurrence est coïncidentielle, si ces effets relèvent d'autres substances souvent associées à la prise de cannabis ou de doses très élevées de cannabis, ou d'interactions entre ces divers facteurs.[19]

Les effets aigus du cannabis sont relativement bien documentés. La recherche distingue parfois entre effets centraux et périphériques[20], parfois entre effets somatiques et effets psychologiques et psychomoteurs[21], ou tout simplement se contente d'une liste d'effets de l'un ou l'autre type.[22]

Règle générale, on distingue deux phases principales à l'intoxication au cannabis :

❖ *La première phase, celle dite du* « high » *(effet planant), inclut les effets suivants :*
- Une modification de l'humeur générale accompagnée de gaieté allant jusqu'à l'hilarité, de loquacité, d'un sentiment d'insouciance ;
- Une modification du vécu corporel, incluant une sensation de bien-être et de satisfaction, une impression de calme et de relaxation, sociabilité ;
- Des perturbations de la sphère intellectuelle incluant augmentation de la confiance en soi, pensées magiques (impression de pouvoir s'acquitter plus facilement de tâches), distorsion de la perception du temps, de l'espace et de l'image de soi ;

---

[17] Moreau de Tours, J., *Du haschich ou de l'aliénation mentale, étude psychologique*. Paris : Masson.

[18] INSERM, *op. cit.*, page 118.

[19] Voir WHO, 1997, *op. cit.*, page 3.

[20] C'est le cas par exemple de la catégorisation proposée par Ben Amar (sous presse).

[21] C'est le cas de l'expertise collective de l'INSERM (2001) *op. cit.*.

[22] C'est le cas de la plupart des travaux : WHO, (1997) *op. cit.* ; Commission fédérale pour les questions liées aux drogues (1999) *Rapport sur le cannabis*. Berne : Office fédéral de la santé publique ; et du rapport de Wheelock (2002) *op. cit.*.

- Des modifications sensorielles, marquées par une accentuation des perceptions sensorielles (couleurs, sons, semblent parfois plus intenses), des impressions tactiles plus fortes.

❖ *La deuxième phase, dite du «* coming down *», se caractérise par un effet de torpeur ou de somnolence apparaissant graduellement quelque temps après la prise.*

De manière plus spécifique selon leur type d'action, on distinguera entre les effets plus proprement somatiques et les effets d'ordre plutôt psychologique.

❖ *Effets somatiques :*

- Des effets cardiovasculaires : environ 10 minutes après la prise, la fréquence et le débit cardiaque et cérébral augmentent. La tachycardie (accélération du cœur) peut atteindre des hausses de 20 % à 50 % par rapport au rythme normal et pourrait contribuer à précipiter des crises d'anxiété et de panique chez certains sujets. Elle peut être responsable de palpitations, de réduction de la tolérance à l'effort chez les sujets ayant des troubles coronariens, voire faciliter le développement de troubles cardiaques chez les sujets vulnérables ou prédisposés. Une étude récente suggère que le risque d'infarctus du myocarde croît de 4,8 fois dans la première heure suivant la consommation de marijuana et se situe à 1,7 fois dans la deuxième heure, suggérant ainsi que le cannabis peut représenter un risque dans les 60 minutes suivant sa consommation. On note aussi une hypotension en position couché. Ces effets varient en fonction de la dose et de la concentration en THC ;
- Des effets bronchopulmonaires : les effets sont proches de ceux du tabac. On note une activité bronchodilatatoire dans les 60 minutes suivant la consommation. Celle-ci n'évite cependant pas les conséquences inflammatoires du cannabis fumé ni l'hyperréactivité bronchique secondaire qui se traduisent notamment par la toux résultant de l'action du THC et du potentiel irritant des produits de combustion ;
- Des effets oculaires : on note une rougeur des yeux par vasodilatation et irritation conjonctivale ;
- Autres effets somatiques : sécheresse buccale par diminution de la sécrétion salivaire, augmentation de l'appétit par hypoglycémie (baisse du taux de sucre sanguin), et plus rarement des nausées et vomissements, de la diarrhée, ou la rétention d'urine.

❖ *Effets psychologiques et psychomoteurs :*

- Diminution de la mémoire à court terme (mémoire dite de travail) : se rappeler des mots, images, des histoires ou des sons ;

- Perturbation des performances psychomotrices incluant : diminution de l'attention et de la concentration, diminution des réflexes, ralentissement du temps de réaction, troubles de la coordination des mouvements et altérations et réduction de l'habileté à accomplir des tâches complexes. Ainsi, une étude de Fant et coll., décrit une diminution de la poursuite visuelle dans le champ central et périphérique après 15 minutes et pouvant se maintenir pendant plus de 5 heures.[23] Par ailleurs, notons que selon le professeur Roques, les études sur les effets du cannabis sur les facultés d'apprentissage, notamment la mémoire à court terme et la mémoire de travail sont critiquables sur le plan méthodologique et leurs résultats contradictoires, « *les plus forts consommateurs étant les moins affectés* ».[24]

Les effets somatiques, cognitifs et psychomoteurs sont reliés à la quantité de cannabis inhalée et à la concentration en THC. Ainsi, selon l'INSERM :

> *« Une quantité correspondant à 25 bouffées altère les compétences psychomotrices et les performances cognitives, cela de façon plus nette que la consommation de 10 bouffées ou de 4 bouffées. Les taux plasmatiques maximaux passent alors de 57 ng/ml (pour 4 bouffées d'une cigarette contenant 1,75 % de Δ^9THC) à 268 ng/ml (pour 25 bouffées d'une cigarette contenant 3,55 % de Δ^9THC). Heishman et coll. (1997) établissent une équivalence approximative entre 16 bouffées à 3,55 % de Δ^9THC et environ 70g d'alcool. À ces doses, l'altération porte sur la mémoire, les performances cognitives et psychomotrices et sur l'humeur. »* [25]

Les effets cognitifs et psychomoteurs peuvent se maintenir durant plus de cinq heures, et la durée de certaines altérations cognitives peut se prolonger pendant 24 heures.

À forte dose, ou pour les usagers inexpérimentés, le cannabis peut entraîner un certain nombre de réactions négatives, pouvant aller jusqu'à une authentique expérience psychotique délirante, hallucinatoire, maniaque ou hypomaniaque. Ces expériences sont cependant transitoires. Certains des troubles documentés lors de l'absorption de fortes doses incluent :

---

[23] Fant, R.V. et coll. (1998) « Acute and residual effects of marijuana in humans. » *Pharmacology, Biochemistry and Behavior*, 60, pages 777-784.

[24] Roques, B. (1999) *La dangerosité des drogues.* Paris :Odile Jacob, page 184.

[25] INSERM, *op. cit.*, page 203.

- anxiété voire crises de panique
- confusion ou désorientation
- vertiges, nausées ou vomissements
- convulsions
- dépersonnalisation
- hallucinations
- paranoïa
- psychose aiguë

Ces phénomènes sont relativement rares (moins de 1 pour mille des admissions psychiatriques). Surtout, il est difficile d'établir que le cannabis en soit la cause. En effet, dans la plupart des cas, l'hypothèse la plus plausible est que ces sujets étaient déjà prédisposés, voire avaient déjà eu des expériences psychotiques ou schizophréniques. La consommation d'autres substances, alcool, autres drogues illicites, ou médicaments, peut aussi jouer un rôle important.

> *« La relation entre l'usage de cannabis et la psychose est une question très controversée. Actuellement, nous ne disposons pas d'un corpus d'études comparables, fiables et produisant des conclusions similaires. Les résultats des études disponibles sont complexes ou ambigus et les opinions personnelles des chercheurs colorent les interprétations. Il nous faut donc améliorer notre base de connaissance scientifique. Néanmoins, il y a un consensus assez répandu, quoique incomplet, sur la possibilité que l'usage intensif ou l'intoxication au cannabis puisse provoquer des états psychotiques transitoires chez des sujets autrement normaux. Nous ignorons la fréquence de cette condition et sommes réduits à des hypothèses sur ses mécanismes. »* [26]

Suivant l'expertise collective de l'INSERM, on peut établir ce qui suit :

> *« Les troubles psychotiques induits par la prise de cannabis sont des épisodes psychotiques brefs, d'une durée inférieure à deux mois, voire quatre mois, parfois à une semaine. La personnalité prémorbide ne présente pas de caractère pathologique. Les consommateurs réguliers sont plus exposés que les consommateurs occasionnels. Le début est brutal, en deux ou trois jours, après ou sans augmentation récente des prises de toxique, avec parfois un facteur précipitant psychologique ou somatique. Certains symptômes apparaissent plus spécifiques : troubles du comportement, agressivité, hallucinations visuelles, aspect polymorphe du délire sur des thèmes divers, désinhibition psychomotrice. (...) Par rapport au trouble schizophrénique, les sujets sont plus jeunes, 20 à 30 ans plutôt que 25 à 30 ans, avec une surreprésentation d'hommes mal socialisés. »* [27]

---

[26] Hanak, C. et coll. (2002) « Cannabis, mental health and dependence. » in Pelc, I. (éd.), *International Scientific Conference on Cannabis*, Bruxelles.
[27] INSERM, *op. cit.*, page 124.

Par contre, ici aussi, les données sont relativement contradictoires et, selon le professeur Roques, il est permis de penser que cet effet soit plus répandu chez les personnes présentant déjà des troubles psychiques.[28]

CONSÉQUENCES DE LA CONSOMMATION CHRONIQUE

La plupart des travaux consultés en pharmacologie, toxicologie et psychiatrie, parlent d'effets chroniques. Nous préférons, pour notre part, parler des *conséquences* induites par une consommation chronique et ce, pour deux raisons. Premièrement, parce que ce n'est pas tant la substance elle-même que la manière de l'utiliser qui induit ces conséquences. Il ne s'agit plus alors des effets de la substance mais des conséquences découlant éventuellement de son utilisation répétée, voire massive. Deuxième raison, les consommateurs chroniques de cannabis comptent, comme nous l'avons vu au chapitre 6, pour une part mineure (souvent moins de 10 %) des usagers vie de cannabis. Il en découle que les conséquences dont il est question dans cette section portent sur cette petite partie de la population des usagers et non sur la substance elle-même.

Cette distinction nous apparaît fondamentale parce qu'il est d'usage fréquent, à tous les niveaux du discours public – qu'il s'agisse de celui des politiques, du grand public, comme des experts – d'incriminer la substance – ici le cannabis, là l'alcool ou les médicaments, voire les autres drogues illicites – quand en fait il faut *apprendre à distinguer entre des formes et manières d'usage*. On parlera alors de conduites à risque, variables selon les substances certes, qui ne dépendent pas que des propriétés intrinsèques de la substance, mais relèvent, dans une approche globale, de la relation entre la substance et sa place dans la société (intégrée ou non), des caractéristiques de l'individu, et de la société dans laquelle la consommation se produit.[29] On comprendra évidemment par là que ***nous distinguons, pour le cannabis comme on le fait pour l'alcool, entre usage, usage à risque et usage excessif*** (ou abus)[30], et que nous refusons l'équivalence souvent faite entre usage et abus où toute forme d'usage est déjà un abus. En même temps, nous sommes conscients aussi du flou qui continue d'entourer ces diverses conduites – ou pratiques – et qu'il n'existe pas de frontière clairement définie ni encore moins universelle entre l'usage, l'usage nocif et la dépendance. Aux fins de ce chapitre, les conséquences dont il est question dans les trois sections suivantes

---

[28] Roques, B., *op. cit.*, page 186.

[29] Cette question sera discutée plus amplement au prochain chapitre. Il suffira pour le moment de renvoyer le lecteur au travail de Reynaud et coll. (1999) *Les pratiques addictives. Usage, usage nocif et dépendance aux substances psycho-actives.* Paris : La Documentation française.

[30] Nous avons établi au chapitre précédent sur les usages et les usagers les paramètres à partir desquels nous faisons cette distinction et nous y revenons dans la conclusion ; nous verrons plus loin dans ce chapitre-ci que la dépendance est une conséquence d'un usage excessif.

renvoient, sans plus de précision, à l'usage chronique (qui regroupe donc les usages à risque et l'usage excessif).

Conséquences physiologiques de l'usage chronique

Les principales conséquences physiologiques de l'usage chronique du cannabis traitées dans la littérature scientifique concernent le système respiratoire et le pouvoir cancérogène du cannabis, le système immunitaire, le système endocrinien et les fonctions de reproduction, et de manière moins importante le système cardiovasculaire.

Conséquences sur le système respiratoire

La fumée de la nicotine du tabac et des cannabinoïdes du cannabis, partagent des propriétés irritantes voire carcinogènes communes. Quoique déjà ancienne, une analyse comparative de ces composants a démontré que la concentration de certains composants à fort pouvoir cancérogène comme le benzopyrène et le benzathracène est plus importante dans la fumée de cannabis que dans celle du tabac.[31] Une étude plus récente citée par l'INSERM confirme cette concentration plus élevée de benzopyrène : 2,9 microgrammes/100 joints contre 1,7 pour 100 cigarettes.[32] Bien entendu, on objectera que les consommateurs de tabac fument généralement beaucoup plus de cigarettes quotidiennes que les usagers de marijuana même chroniques, que c'est le volume total de substances toxiques inhalées au fil du temps qui compte, et qu'il peut être difficile de distinguer les effets du cannabis de ceux du tabac puisque les joints fumés contiennent souvent les deux produits et que les consommateurs de cannabis sont aussi souvent des fumeurs de tabac.[33]

Notons cependant d'autres caractéristiques préoccupantes quant aux effets potentiels du cannabis fumé sur les voies respiratoires. D'abord, la concentration de benzopyrène dans le goudron de marijuana est 70 % plus élevée que celle d'un même poids de goudron de tabac. De plus, à poids égal de produit, le cannabis fournit jusqu'à 4 fois plus de goudron que le tabac fort. Selon une étude citée par l'INSERM les goudrons d'un joint varient entre 40 et 56 mg/cigarette tandis que la dose admissible pour une cigarette de tabac européenne est de 12 mg.[34] Ensuite, une cigarette de marijuana sera généralement fumée de façon beaucoup plus complète qu'une cigarette de tabac, l'inhalation – partie importante du rituel – est plus profonde et la fumée retenue plus longtemps dans les poumons et la température de combustion du cannabis plus élevée que celle du tabac. Ainsi, le pourcentage de goudron déposé dans les poumons est plus élevé après consommation de cannabis fumé (> 80 %) qu'après inhalation de tabac (64 %) et les dépôts seraient même plus élevés dans le cas de

---

31 Institute of Medicine (1982) *Marihuana and Health.* Washington, DC : National Academy of Sciences.

32 INSERM (2001), *op. cit.*, page 222.

33 Ce sont là par exemple les critiques qu'ont faites Zimmer L., et J.P. Morgan (2000 pour la version française ; 1997 pour l'original américain) *Marijuana. Mythes et réalités.* Paris : Georg éditeur.

34 *Ibid.*, page 221.

cannabis moins concentré en THC probablement parce que les fumeurs tirent davantage sur le joint.[35]

Selon le rapport de l'INSERM, la consommation chronique de cannabis « *entraîne des perturbations bronchiques indiscutables (...) bronchite chronique avec toux chronique, expectoration et râles sibilants* »,[36] conclusion partagée par l'Institut de médecine des États-Unis dans son récent rapport sur la marijuana[37] ainsi que par l'OMS.[38] D'autre part, les macrophages (cellules qui attaquent les corps étrangers) des alvéoles pulmonaires semblent perdre leur pouvoir de neutralisation des bactéries lorsqu'exposés à la fumée de cannabis, d'où une sensibilité plus grande des bronches et des poumons aux infections bactériennes. Selon certains auteurs, une cigarette de cannabis pourrait causer théoriquement autant de dommages que 4 à 10 cigarettes de tabac.[39] Ces données sur la diminution de la capacité des macrophages alvéolaires de détruire les bactéries suggèrent aussi que le cannabis pourrait avoir une action immunodépressive diminuant la capacité de l'organisme, ici les poumons, à lutter contre les cellules cancérogènes.

Les travaux de Tashkin notamment mais aussi d'autres chercheurs ne sont pas aussi affirmatifs quant aux effets du cannabis sur les voies respiratoires. Ainsi, une étude récente de Tashkin sur de grands fumeurs de cannabis a démontré qu'il n'y avait pas de diminution du rapport volume expiratoire maximal par seconde/capacité vitale même chez les fumeurs de 3 joints par jour comparativement aux fumeurs de tabac qui enregistraient une perte significative.[40] L'équipe de Tashkin remet aussi en question le développement d'emphysème chez les usagers de cannabis et l'obstruction des bronchioles.[41] De même une étude du *Kaiser Permanent Medical Care Program* a démontré que les usagers quotidiens de cannabis qui ne consommaient pas de tabac étaient à peine plus sujets que les non-fumeurs (36 % c 33 %) à consulter pour problèmes de rhumes, grippes ou bronchites.[42] Notons aussi que les études sont à ce jour contradictoires sur l'addictivité des effets du tabac et du cannabis.

Potentiel cancérogène

En ce qui concerne le potentiel cancérogène du cannabis, on distingue entre les effets cancérogènes de la fumée du cannabis – source potentielle de cancer du poumon

---

35 *Ibid.*, page 221

36 *Ibid.*, page 218.

37 Joy, J.E. et coll., (1999) *Marijuana and Medicine : Assessing the Science Base.* Washington, DC : Institute of Medicine.

38 WHO (1997) *op. cit.*

39 Ben Amar (sous presse), *op. cit.*, page 18.

40 Tashkin, D.P. et coll., (1997) «Heavy habitual marijuana smoking does not cause an accelerated decline in FEV1 with age : a longitudinal study. » *American Journal of Respiratory Critical Care*, 155, pages 141-148.

41 Voir Zimmer et Morgan, *op. cit.*, page 148.

42 Polen, M.R. (1993) « Health care use by frequent marijuana smokers who do not smoke tobacco. ». *Western Journal of Medicine*, 158, pages 596-601.

notamment – et les effets mutagènes du THC sur les cellules. Selon la majorité des auteurs, le THC lui-même ne semble pas cancérogène.[43] Par contre, la fumée de cannabis, comme celle du tabac, semble effectivement susceptible d'augmenter la propension aux tumeurs cancéreuses.

Les travaux de Fliegel[44] indiquent que des modifications histologiques que l'on considère être des précurseurs de carcinomes sont présentes chez les fumeurs chroniques de cannabis. Ces données sont aussi soutenues par des cas cliniques de cancers du tractus supérieur aérodigestif chez des jeunes adultes fumeurs de cannabis, cancers de types rarement observés chez des sujets jeunes. Ainsi :

- Treize cas de cancers du cerveau et du cou chez de jeunes adultes de moins de 40 ans, dont onze étaient des fumeurs quotidiens de cannabis[45];
- Dix cas de cancers du tractus respiratoire supérieur chez de jeunes adultes de moins de 40 ans dont sept étaient des consommateurs réguliers probables de cannabis; [46] et
- Deux cas de carcinome de la langue chez des hommes entre 37 et 52 ans dont le seul facteur de risque commun était la consommation régulière et journalière de cannabis.[47]

On constate d'abord le petit nombre de cas, surtout lorsqu'on compare au grand nombre d'usagers de cannabis. Ces cas cliniques présentent aussi un certain nombre de limites importantes : aucun ne comparait la prévalence de cancer avec un groupe de contrôle ni n'évaluait la consommation de cannabis de manière standardisée. Les interprétations sont aussi limitées par le fait que les patients étaient aussi fumeurs de tabac et usagers d'alcool.

Les données disponibles semblent indiquer que la conséquence d'un usage chronique et intense de cannabis (plusieurs joints par jour sur plusieurs années) serait semblable à celle de la cigarette en termes de risques cancérogènes sur les voies

---

[43] Voir notamment les conclusions de INSERM (2001), *op. cit.* ; ainsi que le rapport de Wheelock (2002) *op. cit.*, pour le Comité du Sénat.

[44] Fligiel S.E.G. et coll., (1988) "Pulmonary pathology in marijuana smokers", in Chesher G. et coll. (eds), *Marijuana: An International Research Report*, National Campaign Against Drug Abuse, Monograph 7, 43-48, Canberra, Australian Government Publishing Service; et Fliegle, SEG et coll., (1997) "Tracheo-bronchial histopathology in habitual smokers of cocaine, marijuana or tobacco" *Chest*, 112, pages 319-326.

[45] Donald P.J. (1991) «Marijuana and upper aerodigestive tract malignancy in young patients», in Nahas, G. et C. Latour (eds.), *Physiopathology of Illicit Drugs: Cannabis, Cocaine, Opiates*, pages 39-54, Oxford ; et (1991) «Advanced malignancy in the young marijuana smoker», in Friedman, H. et coll., (eds.), *Drugs of Abuse, Immunity and Immunodeficiency*, pages 33-36, London.

[46] Taylor, F.M. (1988) « Marijuana as a potential respiratory tract carcinogen: A retrospective analysis of a community hospital population », *Southern Medical Journal* 81, pages 1213-1216.

[47] Caplan, G.A. et B.A. Brigham (1990) « Marijuana smoking and carcinoma of the tongue: Is there an association? » *Cancer 66*, pages 1005-1006.

respiratoires ainsi que la bouche, la langue et l'œsophage.[48] L'on considère généralement que le THC modifie les fonctions de certaines cellules, notamment les lymphocytes, les macrophages et les cellules polymorphonucléiques, notamment dans les modèles *in vitro*. La poursuite d'études contrôlées est toutefois largement reconnue comme une priorité de recherche dans ce domaine.[49]

Conséquences sur le système immunitaire

Hormis les conséquences possibles sur le système de défense des voies respiratoires causées par la fumée essentiellement, il n'y a pas de données concluantes sur les effets du cannabis sur le système immunitaire. Certaines études chez les rongeurs démontrent que les cannabinoïdes, y compris le THC, modifient à haute dose l'immunité cellulaire. Dans certains cas, l'activité expérimentale des cannabinoïdes est immunosuppressive, dans d'autres cas elle est stimulante. Ces variations dépendent de facteurs expérimentaux tels que la concentration de la substance, le moment et la durée de l'administration et le type de fonction cellulaire étudiée. Très peu de travaux ont été faits sur des humains. Selon le rapport de l'OMS, s'il est clair que les cannabinoïdes ont des propriétés immunomodulatrices, il est aussi clair que le système immunitaire est résistant à cette substance. Plusieurs des effets sont relativement minimes et totalement réversibles, et ne se font sentir qu'à des doses plus élevées que celles requises pour les effets psychoactifs de la drogue chez les humains. Enfin, toujours selon le rapport de l'OMS, même en ce qui concerne les effets immunomodulateurs de la fumée de cannabis, les études ne sont pas concluantes et les doses utilisées dans les schémas expérimentaux avec des animaux sont difficilement comparables à celles que consomment les humains. Le rapport conclut que des études rigoureuses sur cette question sont nécessaires.[50]

Conséquences sur le système endocrinien et la reproduction

Les anomalies endocriniennes sont bien répertoriées chez l'animal : chez le rat mâle, on note, à haute dose, une diminution de sécrétion de testostérone avec atrophie testiculaire, des perturbations de la production de sperme, de sa mobilité et de sa viabilité, et une modification du comportement sexuel. Le cycle ovulatoire de la femelle est altéré. Chez l'humain, les résultats sont contradictoires, notamment parce que les observations ne sont pas constantes d'une étude à l'autre mais aussi parce que des changements similaires se produisent suite à l'absorption de drogues prescrites. De plus, les modifications observées sont souvent à la limite de la normale et leurs conséquences cliniques restent discutées.[51]

---

[48] MacPhee, D., (1999) «Effects of marijuana on cell nuclei», in Kalant, H. et coll. (eds.), *The Health Effects of Cannabis*, Toronto : Addiction Research Foundation.

[49] Notamment WHO (1997), *op. cit.* ; Hall, W. et N Solowij (1998) « Adverse effects of cannabis » *The Lancet*, 352, no 9140, page 6 ; INSERM (2001), *op. cit.*

[50] WHO (1997), *op. cit.*, page 26.

[51] INSERM (2001), *op. cit.*, pages 219-220.

Au niveau de la reproduction, le fait que les composés actifs du cannabis passent la barrière placentaire est bien acquis. Néanmoins, la question des effets potentiels du cannabis sur la descendance des femmes est loin d'être résolue et ce d'autant que les études sont méthodologiquement pauvres. Ainsi, lorsqu'on étudie les femmes enceintes usagers de cannabis, elles proviennent souvent de milieux socioéconomiques faibles – et on sait par ailleurs que le niveau socioéconomique est un facteur discriminateur du poids et de la taille des bébés – et il est difficile d'isoler l'effet d'autres facteurs, dont la consommation de tabac et d'alcool – dont on sait qu'ils sont des facteurs de risque de naissance prématurée et de poids et taille plus faibles. De fait, les études sur les fumeuses occasionnelles de cannabis ne démontrent pas de différence significative par rapport aux non fumeuses. Et au total, la plupart des études n'ont pas observé de différences significatives.[52] Les rapports de l'OMS et de l'expertise collective de l'INSERM concluent néanmoins que, malgré les difficultés méthodologiques, il existe une évidence raisonnable que l'usage du cannabis durant la grossesse nuit au développement fœtal, notamment une réduction de la croissance et d'anomalies de comportements, mais que ces anomalies sont plutôt mineures.[53]

Quant aux conséquences néonatales de la consommation de cannabis par les mères pendant la grossesse, les études longitudinales sur des cohortes d'enfants menées par l'équipe du psychologue Peter Fried à Ottawa depuis 1978[54] ne sont pas concluantes. Sur l'ensemble des mesures effectuées, il ressort plus de ressemblances que de différences entre les enfants des fumeurs et des non-fumeurs. Et lorsque des différences sont observées, elles sont mineures et il demeure impossible de dissocier les effets de diverses substances, notamment du tabac et de l'alcool. Enfin, ces études portent sur un petit échantillon d'enfants à partir duquel on ne peut généraliser. Une autre étude longitudinale, rapportée par l'INSERM, portant sur 636 sujets, conclut « *à une relation significative entre les troubles du comportement à l'âge de 10 and et l'exposition prénatale au cannabis.* » Toutefois, le rapport de l'INSERM note aussi que « *(s)i les résultats de ces deux études semblent bien converger (...) il ne faut toutefois pas oublier que l'environnement postnatal peut jouer un rôle important dans la persistance des anomalies du comportement.* »[55]

Conséquences sur le système cardiovasculaire

Il est possible que la prise chronique de cannabis entraîne des complications cardiovasculaires pour les personnes prédisposées. De fait, la prise de quantités importantes peut ralentir la fréquence cardiaque. De même, le cannabis peut avoir des effets similaires à ceux du tabac sur les fonctions cardiaques en augmentant le travail

---

[52] Wheelock (2002), *op. cit.*, page 29.

[53] WHO (1997), *op. cit.*, page 24 ; INSERM, *op. cit.*, page 237.

[54] Fried, P.A. (1995) « Prenatal exposure to marijuana and tobacco during infancy, early and middle childhood : Effects and attempts at a synthesis. » *Archives of Toxicology*, 17 ; et Fried P.A. et B. Watkinson (1999) «36- and 48-month neurobehavioral follow-up of children prenatally exposed to marijuana, cigarettes and alcohol. » *Journal of Deviant Behavior and Pediatrics.* 11, pages 49-58.

[55] INSERM (2001) *op. cit.*, page 235.

musculaire. D'autre part, certaines études mettent en évidence le rôle du monoxyde de carbone trouvé dans la fumée du cannabis sur les risques de complications cardiovasculaires.

Conséquences cognitives et psychologiques

Les principales conséquences cognitives et psychologiques de la consommation chronique de cannabis concernent les fonctions cérébrales relatives à la mémoire et aux compétences verbales et mathématiques, la motivation, et les désordres psychiatriques.

Fonctions cérébrales

Nous avons vu que le cannabis a des effets aigus sur la mémoire à court terme, l'attention et la concentration. La consommation chronique entraîne-t-elle à terme des effets qui pourraient être irréversibles sur les fonctions cognitives ? Ces questions soulèvent d'abord celle de la neurotoxicité du cannabis, définie comme « *une atteinte réversible ou irréversible de la structure et/ou des fonctions du système nerveux central (et/ou périphérique) par des agents physiques, chimiques ou biologiques.* »[56]

Selon le professeur Roques :

> « *La toxicomanie au cannabis n'entraîne pas de neurotoxicité. (…) Ainsi les résultats anciens suggérant des modifications anatomiques dans le cerveau des consommateurs chroniques de cannabis mesurées par tomographie n'ont pas été confirmés par les techniques modernes précises de neuro-imagerie. De même les altérations morphologiques dans l'hippocampe de rat après administration de doses très élevées de THC (Landfield et al., 1988) n'ont pas été retrouvées (Slikker et al., 1992). (…) Plusieurs études ont été consacrées aux effets du cannabis sur les potentiels évoqués et sur l'électroencéphalogramme chez l'homme. L'usage intermittent produit des changements réversibles dans les profils d'ondes α dans le cortex frontal probablement en rapport avec les états de somnolence induits par le THC. À très long terme (plus de quinze ans) et avec une forte consommation journalière, une augmentation dans l'activité frontale θ et une hyperfrontalité δ ont été observés (Struve et al., 1990, 1994). La relation éventuelle avec des changements comportementaux ou dans des tests neuropsychologiques n'est pas discutée ni, du reste, celle possible avec les effets anticonvulsivants du THC.* »[57]

Les résultats des études rapportées par l'expertise collective de l'INSERM sont contradictoires, certaines observant des changements, d'autres non. Même lorsque des changements sont observés, ils sont souvent d'amplitude mineure et réversibles après une période d'abstinence. Le rapport de l'INSERM observe que les études utilisant les techniques de neuro-imagerie n'ont pas confirmé la présence d'une neurotoxicité du cannabis ni chez l'homme ni chez le babouin.[58] C'est donc par l'observation des

---

[56] Roques, B., (1999) *op. cit.*, page 73.
[57] *Ibid.*, page 187.
[58] INSERM, *op. cit.*, page 206

fonctions et des comportements que l'on sera encore le mieux à même d'examiner la question des effets neurologiques du cannabis.

Malheureusement, les études sont ici aussi contradictoires et les résultats non concluants. Des études réalisées dans les années 1970 dans des pays où la consommation de cannabis est traditionnelle (Jamaïque, Costa Rica, Inde) ne faisaient pas ressortir de différences significatives entre usagers et non-usagers sur les fonctions cognitives, tandis que des études plus récentes, notamment au Costa Rica dans les années 1980, démontraient des différences : « *En particulier, les usagers de longue date se rappelaient moins de mots d'une liste présentée auparavant et le temps de réponse était plus long.* »[59] Aux États-Unis, les études menées dans les années 1970 observaient des résultats contradictoires sur les fonctions mnésiques, tandis que des études plus récentes ont rapporté des déficits subtils de fonctions cognitives chez les grands consommateurs après une brève période d'abstinence. Certaines études démontrent aussi une persistance des perturbations mnésiques chez les adolescents après six semaines d'abstinence.[60]

La plupart des études tendent à démontrer que les ex-consommateurs récupèrent globalement l'ensemble des fonctions cognitives, mais selon la durée de la consommation des perturbations subtiles pourraient persister, notamment sur la capacité à traiter des informations complexes.

Toujours selon l'expertise collective de l'INSERM, l'âge de début de la consommation pourrait être un facteur discriminant. Ainsi, une étude récente démontre la persistance de certaines perturbations de la fonction de balayage visuel (reliée à l'attention) chez les jeunes ayant commencé à consommer du cannabis avant l'âge de 16 ans, alors que ceux ayant commencé à consommer après 16 ans ne démontraient pas de différences avec les non-consommateurs.[61]

Au total, on ne peut guère établir que la consommation de cannabis aurait des conséquences négatives sur les fonctions cérébrales, même chez les consommateurs chroniques, sauf si la consommation débute avant l'âge de 16 ans.

La motivation

Certaines études suggèrent la présence d'un syndrome amotivationnel chez les usagers chroniques de cannabis, syndrome qui pourrait notamment affecter la performance des jeunes à l'école et des travailleurs en milieu professionnel. Dans son rapport de 1997, l'OMS souligne que l'état des connaissances n'a pas progressé depuis son précédent rapport en 1981 : le syndrome amotivationnel n'a toujours pas été clairement défini, ses effets ne sont toujours pas clairement distingués des effets de l'intoxication elle-même, et les données disponibles proviennent de rapports de cas cliniques sans groupe contrôle.[62]

---

[59] *Ibid.*, page 204.
[60] *Ibid.*, page 205.
[61] *Ibid.*, page 206.
[62] WHO (1997), *op. cit.*, page 18.

Afin d'évaluer l'impact du cannabis sur la motivation, des chercheurs canadiens ont conçu une étude où les sujets recevaient du cannabis en échange d'un travail accompli. Même si elle est déjà ancienne, l'étude n'est pas moins intéressante. Ils ont observé que les sujets travaillaient moins efficacement immédiatement après avoir consommé du cannabis. Toutefois, leur niveau de productivité augmentait ensuite rapidement et surpassait les niveaux atteints lors des périodes d'abstinence. Bien que travaillant le moins d'heures, les sujets consommant le plus de cannabis n'étaient pas moins productifs parce qu'ils travaillaient avec plus d'ardeur. De plus, au cours de la période la plus intense de consommation, les sujets ont organisé une grève et ont négocié avec succès une augmentation de leurs « revenus », après laquelle ils ont travaillé avec encore plus d'intensité.[63] [64]

Les études ne permettent pas d'établir si les troubles de la motivation, lorsque constatés, sont antérieurs ou postérieurs à la consommation de cannabis ni si d'autres facteurs d'ordre émotionnel ou psychosocial ne sont pas davantage déterminants, voire même déterminants de la consommation chronique ou abusive de cannabis chez les jeunes notamment. Ces conclusions sont partagées par l'expertise collective de l'INSERM et par les auteurs du rapport présenté à la Conférence scientifique internationale sur le cannabis de mars 2002.[65]

Désordres psychiatriques

Divers désordres psychiatriques ont été associés à la consommation chronique de cannabis : troubles de l'humeur et épisodes dépressifs, troubles anxieux, troubles de la personnalité, ainsi que des conditions plus sévères comme les psychoses et la schizophrénie. Pour chacune de ces situations, la conclusion que tirent les auteurs du rapport sur la santé mentale et le cannabis préparé pour la Conférence scientifique internationale sur le cannabis s'applique généralement :

> *« On peut expliquer de trois manières la relation entre le cannabis et les désordres de l'humeur. Premièrement, ils partagent des facteurs de risque communs de sorte qu'ils ne sont pas en relation causale. Deuxièmement, les désordres de l'humeur peuvent prédisposer les personnes à consommer du cannabis. Et troisièmement, le cannabis peut susciter ou augmenter les symptômes dépressifs. Il n'existe pas, à l'heure actuelle, de réponse claire à la question de savoir lequel arrive en premier. »* [66]

En ce qui concerne spécifiquement les troubles de l'humeur, les états dépressifs et les troubles anxieux, il semble vraisemblable qu'ils précèdent la consommation chronique. De toutes façons, les résultats des études sont extrêmement disparates :

---

[63] Miles G.C. et coll., (1974) *An Experimental Study of the Effects of Daily Cannabis Smoking on Behavioural Patterns*, Toronto : Addiction Research Foundation, Toronto.

[64] Campbell, I. (1976) *The Amotivational Syndrome and Cannabis Use With Emphasis on the Canadian Scene*, Annals of the New York Academy of Sciences 282, pages 33-36.

[65] INSERM, op.cit. ; Hanak, C. et coll., (2002) « Cannabis, mental health and dependence », Pelc, I. (éd.), *International Scientific Conference on Cannabis*, *op. cit.*, page 61.

[66] Hanak, C. et coll (2002), *op. cit.* page 62.

pour les troubles de l'humeur chez les personnes dites dépendantes, la prévalence varie (selon les méthodes d'enquête), de 10 % à près de 50 % ; pour ce qui concerne les épisodes dépressifs majeurs dans les populations cliniques, les études rapportent des pourcentages variant de 4 % à près de 20 %. Le rapport de l'INSERM propose un compte-rendu qui nous paraît beaucoup plus éclairant de la situation chez les adolescents :

> *« L'acquisition de nouvelles connaissances a permis de mieux mesurer le poids de la pathologie « dépressive précoce » en termes de souffrance individuelle et de santé publique. Sa prévalence, de l'ordre de 5 % à l'adolescence, en fait l'une des pathologies les plus fréquentes à cette période. Le risque suicidaire est élevé, et les déficits fonctionnels inhérents aux syndromes dépressifs sont sources de difficultés scolaires, de problèmes familiaux, de retraits vis-à-vis des pairs, dont les conséquences psychosociales peuvent être sévères surtout si le trouble se prolonge. De plus, la dépression du sujet jeune est rarement isolée : troubles anxieux ou troubles des conduites précèdent ou accompagnent souvent des épisodes dépressifs et peuvent leur survivre ; l'existence de troubles dépressifs est par ailleurs un facteur de risque d'addiction (alcool ou toute autre substance psychoactive) ou de troubles de conduite alimentaire. »* [67]

En ce qui concerne les troubles psychotiques et la schizophrénie, les deux sujets sont controversés, les méthodologies faibles, les données contradictoires et les interprétations souvent basées sur des modèles simplistes de la causalité. Si le cannabis peut dans certaines circonstances déclencher des épisodes psychotiques, ils sont le plus souvent courts et se résorbent rapidement. Quant à la schizophrénie, s'il est vrai que ces sujets ont une prévalence d'usage de cannabis plus élevée qu'en population générale, certains considèrent qu'il s'agirait d'un comportement d'automédication, tandis que d'autres considèrent que la consommation chronique de cannabis serait un facteur activateur du processus schizophrénique. La conclusion du rapport du professeur Roques nous semble la plus en accord avec les données existantes actuellement :

> *« Aucune pathologie mentale directement reliée à la surconsommation de cannabis n'a été signalée, ce qui différencie cette substance des psychostimulants tels que la MDMA, la cocaïne ou l'alcool dont l'usage excessif et répété peut donner lieu à des syndromes psychotiques caractéristiques. De même, le cannabis ne semble pas précipiter l'apparition de dysfonctionnements mentaux préexistants (schizophrénie, dépression bipolaire, etc.). »* [68]

En l'état, la plupart des rapports scientifiques s'entendent pour conclure qu'il convient de mener davantage de recherche, avec des protocoles plus rigoureux, permettant notamment la comparaison avec d'autres populations et d'autres substances.

---

[67] INSERM (2001), *op. cit.*, page 98.

[68] Roques, B., (1999) *op. cit.*, page 186.

Conséquences comportementales et sociales

Les principales conséquences comportementales et sociales examinées dans la littérature scientifique portent sur l'ajustement social et familial, l'agressivité, et la capacité à accomplir des tâches complexes.

Ajustement social et familial

Selon certaines études, la consommation chronique de cannabis pourrait avoir des conséquences sur l'ajustement social et familial. Ainsi, les usagers chroniques auraient plus de difficultés à conserver un emploi ; seraient plus souvent au chômage ; auraient plus de difficultés d'ajustement interpersonnel.[69]

Toutefois, la plupart de ces études souffrent de problèmes méthodologiques et de difficultés d'interprétation. La plupart des études portent sur des échantillons de personnes qui proviennent majoritairement de milieux socioéconomiques défavorisés. Surtout, au delà de l'association statistique, il est difficile de déterminer dans quelle mesure d'autres facteurs ne jouent pas un rôle prépondérant où le cannabis est lui-même un symptôme et non une cause.

Agressivité

Contrairement à d'autres substances psychoactives, l'alcool et la cocaïne notamment, le cannabis n'entraîne pas d'agressivité. Certains auteurs, examinant les symptômes de sevrage lorsqu'une dépendance s'est installée, notent une irritabilité plus grande ; mais celle-ci est même moins importante proportionnellement que celle induite par le tabac.

Accomplir des tâches complexes

Aucune étude sur la consommation chronique de cannabis n'a pu établir que le cannabis entraîne des effets à long terme sur la capacité à accomplir des tâches complexes. Cette donnée est conforme à l'absence de neurotixicité du cannabis.

---

[69] INSERM, (2001) *op. cit.*, pages 206-207.

TOLÉRANCE ET DÉPENDANCE

Qui pense drogue pense toxicomanie puisque, comme le rappelle F. Caballero, est drogue « toute substance susceptible d'engendrer la toxicomanie ».[70] En France et en Europe, les observatoires créés ces dernières années s'appellent observatoires des drogues et des toxicomanies. Au Québec, l'organisme conseil créé par le Gouvernement se nomme Comité permanent de lutte à la toxicomanie. Partout, dans des textes de loi, dans des documents d'information, dans le langage courant, on retrouve le terme de toxicomanie. Pourtant, dès 1963, l'OMS recommandait d'abandonner ce terme pour cause d'imprécision et de référer plutôt aux états de dépendance physique ou psychique définis comme suit :

> *« La dépendance psychique est un « état dans lequel une drogue produit un sentiment de satisfaction et une pulsion psychique exigeant l'administration périodique ou continue de la drogue pour provoquer le plaisir ou éviter le malaise.*
> *La dépendance physique est un « état adaptatif caractérisé par l'apparition de troubles physiques intenses lorsque l'administration de la drogue est suspendue ou que son action est contrecarrée par un antagoniste spécifique. Ces troubles, c'est-à-dire les symptômes de sevrage ou d'abstinence, se composent de symptômes et de signes de nature physique ou psychique qui sont caractéristiques de chaque drogue.» »*[71]

De surcroît, avec l'extension de la notion de drogues à d'autres substances (produits pharmaceutiques, tabac, alcool), et avec l'extension du contrôle international des substances aux psychotropes, l'OMS crée, en 1969, une nouvelle définition sous le vocable de pharmacodépendance qui, s'il est d'abord d'application réduite aux seuls médicaments, en viendra avec le temps à recevoir une acception plus large :

> *« La pharmacodépendance est un état psychique et quelquefois physique résultant de l'interaction entre un organisme vivant et un médicament, se caractérisant par des modifications du comportement et par d'autres réactions qui comprennent toujours une pulsion à prendre le médicament de manière continue ou périodique de façon à retrouver ses effets psychiques et quelquefois d'éviter le malaise de sa privation. Cet état peut s'accompagner ou non d'une tolérance. Un même individu peut être dépendant de plusieurs médicaments. »*[72]

Mais il est encore plus intéressant pour notre propos de citer des définitions plus anciennes de l'OMS portant ici sur les termes accoutumance et toxicomanie ou assuétude :

---

[70] Caballero, F. et Y. Bisiou (2000) *Droit de la drogue.* Paris, Dalloz, 2eme édition, page 3.

[71] OMS (1964) *Comité d'experts des drogues engendrant la dépendance*, Série de rapports techniques, no 273, cité in Caballero et Bisiou, *op. cit.*, pages 5-6.

[72] OMS (1969) *Comité d'experts de la pharmacodépendance*, Série de rapports techniques, no 407, cité in Caballero et Bisiou, (2000), *op. cit.*, page 6.

« L'accoutumance (en anglais habituation) est un état résultant de la consommation répétée d'une drogue. Ses caractéristiques sont notamment :

1. *Un désir (mais non une obligation) de continuer à prendre de la drogue à cause de la sensation de bien-être qu'elle engendre ;*
2. *Peu ou pas de tendance à augmenter les doses ;*
3. *Une dépendance d'ordre physique à l'égard des effets de la drogue, mais absence de dépendance physique et par conséquent pas de syndrome d'abstinence ;*
4. *Des effets nuisibles qui, s'ils existent, concernent avant tout l'individu*

La toxicomanie ou assuétude (en anglais addiction) est un état d'intoxication chronique ou périodique engendré par la consommation répétée d'une drogue naturelle ou synthétique. Ses caractéristiques sont notamment :

1. *Un invincible désir ou un besoin de continuer à consommer de la drogue et de se la procurer par tous les moyens ;*
2. *Une tendance à augmenter les doses ;*
3. *Une dépendance psychique et généralement physique à l'égard des effets de la drogue ;*
4. *Des effets nuisibles à l'individu et à la société. »*[73]

L'intérêt de cette définition est de permettre mieux que les deux précédentes de distinguer entre les drogues créant principalement une accoutumance et celles créant la toxicomanie c'est-à-dire le besoin irrépressible d'en consommer. Or, comme nous le verrons dans ce chapitre, le cannabis correspond bien davantage aux critères d'une substance susceptible de créer une certaine accoutumance et non la toxicomanie.

En plus de penser à toxicomanie, penser drogue c'est aussi penser substances illicites. Or, comme l'ont établi un large éventail de travaux et de plus en plus de pratiques, la distinction matériellement effective se situe sur les plans conjugués de la toxicité de la substance (sa dangerosité) et des usages (consommation, abus, excès) qui la caractérisent, et non sur le plan du statut juridique et symbolique de la substance.

Dépendance au cannabis

Établissons d'abord que les études animales sur la dépendance et le sevrage sont très peu pertinentes puisque la plupart utilisent des doses qui n'ont rien en commun avec celles que consomment les humains, même usagers chroniques. Par ailleurs, notons que les études sur les animaux naïfs (non expérimentés à d'autres drogues) n'ont pu établir un comportement d'autoadministration. Or, il s'agit de la seule technique permettant d'évaluer directement les propriétés renforçantes d'une molécule. L'une des explications probables tient à la demi-vie plasmatique longue du Δ^9THC, dont on sait qu'il est éliminé lentement par l'organisme (jusqu'à 27 jours comme nous l'avons vu au chapitre 5).[74] Notons encore que, même après l'administration de doses très élevées de

[73] OMS (1952) *Comité d'experts des drogues susceptibles d'engendrer la toxicomanie*, Série des rapports techniques, no 57, cité in Caballero et Bisiou (2000), *op. cit.*, pages 4-5.
[74] INSERM, (2001), *op. cit.*, pages 274-275.

Δ^9THC, des signes somatiques de sevrage spontané ne sont pas observés chez le rongeur, le pigeon, le chien ou le singe.[75] Notons enfin que l'on connaît peu, somme toute, les mécanismes biophysiologiques et psychologiques de la dépendance.

La notion de dépendance au cannabis a fait l'objet de critiques tenant à son côté trop médical (tenant peu compte de l'inscription sociale différentielle des modes et contextes d'usage) et au raisonnement circulaire (par exemple, le fait que les drogues soient illégales fait que leur consommation est nécessairement illégale, alors même que ce critère est utilisé dans la nosologie psychiatrique comme l'un des symtômes de dépendance.).[76] Néanmoins, un syndrome de dépendance au cannabis ne diffère pas, lorsque mesuré par les critères du DSM, du syndrome de dépendance à l'alcool ou à l'héroïne. De plus, établir la dangerosité relative du cannabis n'est pas contradictoire avec des objectifs de santé publique.

Les critères nosologiques du DSM-IV (*Diagnostic and Statistical Manual of Mental Illnesses*) de *l'American Psychiatric Association* demeurent sans doute les plus utilisés dans les études sur les dépendances, d'autant plus que la plus grande partie de la recherche sur les drogues est menée aux États-Unis et dans les pays anglo-saxons (Royaume-Uni, Australie, Canada…) qui utilisent cet instrument.

Le DSM IV distingue entre les critères d'abus de substance et les critères de dépendance. Nous les reproduisons ici d'après le rapport de l'INSERM.

Critères diagnostics d'abus de substance d'après le DSM-IV
A. Mode d'utilisation d'une substance conduisant à une altération du fonctionnement ou à une souffrance cliniquement significative caractérisée par la présence d'une au moins des manifestations suivantes au cours d'une période de 12 mois :
1. Utilisation répétée d'une substance conduisant à l'incapacité de remplir des obligations majeures au travail, à l'école ou à la maison ;
2. Utilisation répétée d'une substance dans des situations ou cela peut être physiquement dangereux ;
3. Problèmes judiciaires répétés liés à l'utilisation d'une substance ;
4. Utilisation de la substance malgré des problèmes interpersonnels ou sociaux, persistants ou récurrents, causés ou exacerbés par les effets de la substance.
B. Les symptômes n'ont jamais atteint, pour cette classe de substances, les critères de dépendance à une substance.

[75] *Ibid.*, page 270.

[76] Cohen, P., directeur du Centre de recherche sur les drogues de l'École des sciences sociales de l'Université d'Amsterdam, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 28 mai 2001, fascicule 3 ; aussi Alexander, B.K., professeur, département de psychologie, Université Simon Fraser, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 23 avril 2001, fascicule 1.

Critères diagnostics de dépendance à une substance d'après le DSM-IV
Mode d'utilisation inadéquat d'une substance conduisant à une altération ou à une souffrance cliniquement significative, caractérisée par la présence d'au moins trois des manifestations suivantes au cours d'une période continue de 12 mois : **1. Tolérance, définie par l'un des symptômes suivants :** **a. Besoin de quantités notablement plus fortes de la substance pour obtenir une intoxication ou l'effet désiré ;** **b. Effet notablement diminué en cas d'utilisation continue d'une même quantité de substance.** **2. Sevrage, caractérisé par l'une ou l'autre des manifestations suivantes :** **a. Syndrome de sevrage caractéristique de la substance ;** **b. La même substance (ou une substance très proche) est prise pour soulager ou éviter les symptômes de sevrage.** **3. La substance est souvent prise en quantité plus importante ou pendant une période plus prolongée que prévu ;** **4. Il existe un désir persistant, ou des efforts infructueux, pour diminuer ou contrôler l'utilisation de la substance ;** **5. Beaucoup de temps est passé à des activités nécessaires pour obtenir la substance, à utiliser le produit ou à récupérer de ses effets ;** **6. Des activités sociales, professionnelles ou de loisirs importantes sont abandonnées ou réduites à cause de l'utilisation de la substance ;** **7. L'utilisation de la substance est poursuivie bien que la personne sache avoir un problème psychologique ou physique persistant ou récurrent, susceptible d'avoir été causé ou exacerbé par la substance.**

L'existence d'un syndrome de dépendance au cannabis chez les humains peut être inférée selon diverses méthodes : les enquêtes épidémiologiques et les études cliniques (qui utilisent le plus souvent les critères du DSM), et la demande de traitement.

Enquêtes épidémiologiques

Certaines études épidémiologiques indiquent que la consommation de cannabis peut mener à une dépendance psychologique. Dans certains cas, on estime que la moitié des usagers chroniques développeraient une dépendance de ce type.[77] Les personnes consommant du cannabis sur une base journalière pendant plusieurs mois seraient plus à risque de développer une dépendance.[78] L'interprétation et la comparaison des diverses études entre elles sont difficiles parce que le dénominateur n'est pas toujours comparable ou même spécifié (dans certains cas, il s'agit de la population générale, dans d'autres des usagers de cannabis, et dans ce dernier cas on ne distingue pas toujours entre usagers à vie, récents et réguliers). Les auteurs ne précisent pas toujours non plus si la dépendance est récente ou à vie.

[77] WHO (1997) *op. cit.*.

[78] Channabasavanna, M, et coll., (1999) « Mental and behavioural disorders due to cannabis use », in Kalant H. et coll. (eds.), *The Health Effects of Cannabis* , Toronto : CAMH.

Aux États-Unis, plusieurs enquêtes ont été menées sur la fréquence d'usage de diverses substances psychoactives et la dépendance. L'étude *Epidemiological Catchment Area* a permis d'interviewer près de 20 000 personnes dans cinq études au cours des années 1980. La prévalence (en population générale) de dépendance au cannabis serait de 4,4 %.[79] *L'étude National Comorbidity Survey*, enquête en population générale sur plus de 8 000 sujets entre 15 et 55 ans entreprise entre 1990 et 1992 pour estimer la comorbidité entre l'abus de substances et d'autres désordres mentaux, a aussi estimé la prévalence de la dépendance. Pour les besoins de l'enquête, les critères du DSM ont été utilisés et la dépendance était observée lorsque les répondants présentaient au moins trois critères sur neuf. Selon cette étude, 4,2 % des 15-54 ans présentent une dépendance au cannabis (14 % à l'alcool et 24 % au tabac). Parmi ceux qui ont consommé du cannabis au moins une fois au cours de leur vie (46 %), 9 % sont considérés dépendants, contre 32 % pour le tabac et 15 % pour l'alcool. La dépendance au cannabis est plus forte chez les hommes que chez les femmes (12 % c 5,5 % des usagers), et chez les 15-24 que chez les autres (15 % c 8 %).[80] Rassemblant les résultats de trois grandes enquêtes auprès des ménages (près de 88 000 répondants de 12 ans et plus) sur la consommation de substances psychoactives Kandel et coll.,[81] observent que 8 % des usagers de cannabis au cours de la dernière année (0,7 % de l'échantillon) sont repérés comme dépendants.

En Nouvelle-Zélande, une étude longitudinale sur une cohorte de 1 265 enfants nés en 1977 en région urbaine suivis depuis la naissance a révélé qu'à l'âge de 21 ans pas moins de 70 % avaient utilisé du cannabis. De ceux-ci, 13 % avaient eu, au cours de leur vie, un problème de dépendance mesuré par le DSM-IV.[82] Une autre étude néo-zélandaise sur une cohorte de 1 000 personnes a observé des résultats similaires : à l'âge de 21 ans 62 % avaient consommé du cannabis, et 70 % à 26 ans. La prévalence de dépendance selon les critères du DSM III-R passe de 3,6 % à 18 ans à 9,6 % à 21 ans (soit près de 15 % des usagers).[83]

---

[79] Anthony J.C. et J.E. Helzer (1991) « Syndromes of drug abuse and dependence », in Robins L.N. et D.A. Regier (eds.), *Psychiatric Disorders in America*, New York, Free Press, pages 116-154.

[80] Anthony, J.C., et coll., (1994) «Comparative epidemiology of dependence on tobacco, alcohol, controlled substances and inhalants : basic findings from the National Comorbidity Survey. » *Experimental and Clinical Psychopharmacology*, 2, pages 244-268.

[81] Kandel, D., et coll., (1997) «Prevalence and demographic correlates of symptoms of last year dependence on alcohol, nicotine, marijuana and cocaine in the US population. » *Drugs, Alcohol and Dependency*, 44, pages 11-29. Voir aussi Kandel D. et M. Davies, (1992) «Progression to regular marijuana involvement: Phenomenology and risk factors for near daily use », in M. Glantz and R. Pickens (eds.), *Vulnerability to Drug Abuse*, pages 211-253, Washington DC, American Psychological Association.

[82] Fergusson, D.M. et L.J. Horwood (2000) « Cannabis use and dependence in a New Zealand birth cohort. » *New Zealand Medical Journal*, 113, pages 156-158

[83] Poulton, R., et coll., (2001) « Persistence and perceived consequences of cannabis use and dependence among young adults : implications for policy. » *New Zealand Medical Journal*, 114, pages 13-16.

En Australie, une enquête en population générale auprès de plus de 10 000 personnes âgées de plus de 18 ans a démontré qu'environ 1,5 % des usagers au cours de la dernière année et 20 % des usagers actuels présentaient des signes de dépendance selon le DSM-IV.[84]

Aux Pays-Bas, une étude sur un échantillon de la population nationale de 18 à 65 ans (7 000 sujets) a démontré que 10 % des usagers avaient eu des signes de dépendance au cours de leur vie.[85]

Études cliniques

Les résultats des études cliniques peuvent difficilement être généralisés mais il est intéressant de voir dans quelle mesure ils se rapprochent des résultats des études épidémiologiques. Kosten a examiné la validité des critères du DSM-III R pour identifier les syndromes de dépendance à diverses substances psychoactives dont le cannabis. Il a observé une forte cohérence des critères pour les syndromes de dépendance à l'alcool, à la cocaïne et aux opiacées. Les résultats étaient plus équivoques sur le cannabis. Une analyse critérié a permis d'identifier qu'il y avait trois dimensions au syndrome de dépendance au cannabis (1) la compulsion – indiquée par une modification des activités sociales attribuable à la drogue; (2) une difficulté à arrêter – révélée par l'incapacité à réduire la consommation, le retour aux niveaux antérieurs après cessation temporaire et un degré de tolérance aux effets; et (3) des indices de sevrage – révélés par leur disparition lors d'une re-consommation et l'usage continue malgré des difficultés reconnues.[86]

Études auprès d'usagers au long cours

Au Canada, une étude du professeur Hathaway menée entre octobre 2000 et avril 2001, tente d'identifier les usages à problème et la dépendance chez les usagers réguliers à partir des critères diagnostics du DSM-IV.[87] L'étude porte sur un échantillon de 104 personnes (64 hommes et 40 femmes) âgées entre 18 et 55 ans (âge moyen de 34 ans) ; 80 % avaient une consommation hebdomadaire et 51 % une consommation quotidienne au cours des 12 derniers mois, et près de la moitié (49 %) déclaraient consommer une once ou plus (28 grammes) en moyenne par mois. Interrogés sur les raisons de leur consommation, les participants citent : pour relaxer (89 %), pour se sentir bien (81 %), pour mieux apprécier la musique ou les films (72 %), pour contrer l'ennui (64 %) et pour favoriser l'inspiration (60 %).

---

[84] Swift, W. et coll., (2001) « Cannabis use and dependence among Australian adults : results from the National Survey of Mental Health and Wellbeing. » *Addiction*, 96, pages 737-748.

[85] Van Laar, M., et coll., (2001) *Nationale Drug Monitor. Jaarbericht 2001.* Utrecht : NDM Bureau.

[86] T.R. Kosten et al., (1987) "Substance-use disorders in DSM-III-R", *British Journal of Psychiatry* 151, pages 8-19.

[87] Hathaway, A.D. (2001) « Cannabis effects and dependency concerns in long-term frequent users : a missing piece of the public health puzzle. » Transmis au Comité du Sénat sur les drogues illicites lors de la comparution du professeur Hathaway devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 14 mai 2001, fascicule no2.

Interrogés sur les activités déviantes reliées à leur consommation de cannabis, la réponse la plus fréquente était de s'être trouvé dans des situations inconfortables pour se procurer du cannabis. Les autres activités mentionnées étaient : emprunter de l'argent, vendre du cannabis pour payer leur propre consommation, et travailler davantage. 6% avaient déjà eu des problèmes légaux reliés à leur consommation de cannabis. En ce qui concerne les critères de dépendance, 30 % des participants déclaraient avoir ressenti trois ou plus d'entre eux au cours de leur vie, 15 % au cours de la dernière année.

> [Traduction] *« (...) les problèmes les plus fréquemment associés au cannabis ont davantage trait aux perceptions qu'ont les usagers de l'usage excessif qu'aux impacts perçus de la drogue sur la santé, les obligations sociales et les relations ou d'autres activités. En accord avec la nature hautement subjective de cette évaluation, nous n'avons observé aucune corrélation significative entre les quantités ou la fréquence d'utilisation et le nombre d'items au DSM-IV. Lorsque les problèmes de dépendance au cannabis progressent au point de demander une aide formelle, la signification substantive de la perception de niveaux d'usage excessifs ne doit pas être sous-estimée. »*[88]

L'étude comparative de Cohen et Kaal sur des usagers au long cours discutée au chapitre précédent incluait aussi des données sur les symptômes de dépendance. Entre 21 et 24 % des répondants présentaient trois ou plus des critères du DSM IV au cours de leur vie. C'est ce que démontre le tableau suivant.

[88] *Ibid.*, page 15.

Nombre de réponses positives aux critères du DSM IV
Amsterdam, San Francisco, Bremen[89]

	Au cours de leur vie				Au cours des 12 derniers mois			
Nombre de	Amsterdam		San Francisco		San Francisco		Bremen	
critères	N	%	N	%	N	%	N	%
0	85	39	129	49	233	88	43	78
1	37	17	53	20	17	6	5	9
2	43	20	30	11	9	3	4	7
3	19	9	28	11	3	1	2	4
4	15	7	15	6	3	1	1	2
5	9	4	7	3				
6	8	4	3	1				
Total	216	100	265	100	265	100	55	100
Moyenne incl 0	1,5		1,2		0,2		0,4	
Moyenne sans 0	2,5		2,3		1,8		1,9	

Les auteurs notent aussi une corrélation significative entre la quantité consommée (en grammes) au cours de la période d'utilisation la plus intensive (au début de la vingtaine chez ces usagers expérimentés au long cours) et le nombre de critères rencontrés, corrélation qu'ils ne retrouvent cependant pas sur la consommation au cours de la dernière année.

Demande de traitement

Enfin, on peut examiner la dépendance indirectement par la demande de traitement. Évidemment, il ne s'agit que d'une mesure très indirecte et sûrement très imparfaite pour plusieurs raisons. La très grande majorité des usagers de cannabis en font un usage irrégulier, qui se termine au début de la vingtaine. Parmi ceux qui continuent et deviennent usagers réguliers, nous venons de voir qu'entre 10 % à 20 % présenterons des critères de dépendance. La plupart des usagers n'ont pas l'impression d'avoir besoin d'aide, ce que confirmerait leur capacité à arrêter l'usage sans recours extérieur. Enfin, parmi ceux qui demandent de l'aide, il peut y avoir à la fois l'influence de la disponibilité des services aussi bien que l'interaction avec d'autres consommations à problème, alcool, médicaments ou autres drogues ou avec d'autres désordres mentaux. De fait, il semble que dans une proportion importante des cas, les demandes de traitement reliées au cannabis proviennent de personnes présentant des désordres multiples.

[89] Cohen, P.D.A. et H.L. Kaal, (2001) *The irrelevance of drug policy. Patterns and careers of experienced cannabis use in the population of Amsterdam, San Francisco and Bremen.* Amsterdam : University of Amsterdam, CEDRO, page 99.

Néanmoins, nous avons entendu des témoignages à l'effet que la demande de traitement pour problème de dépendance au cannabis serait en croissance et que cette augmentation pourrait être reliée au contenu en THC.

En Europe, la demande de traitement pour problème principal relatif au cannabis varie largement entre pays passant de 6 % en Espagne (l'un des pays où la consommation est la plus répandue et la plus tolérée) à 25 % en Belgique. La Suède, qui a pourtant un taux de consommation relativement faible, a une demande de traitement de 14 %, comparable à celui de la France (16 %) qui a pourtant un taux d'usage beaucoup plus élevé. Aux États-Unis, la demande est tout aussi variable selon les états, entre 5 % et 30 %.[90]

Sévérité de la dépendance

La sévérité de la dépendance a été évaluée de différentes manières. Aux États Unis, une étude a examiné environ 1 100 sujets ayant consommé plus de 6 fois du cannabis et a évalué la sévérité de leur dépendance à partir des critères du DSM IV. Le niveau de dépendance (basse, intermédiaire ou élevée) correspondait au nombre de critères remplis.[91] On obtient les résultats suivants :

Sévérité de la dépendance au cannabis en fonction de la consommation[92]

	Répartition des sujets en fonction du type de consommation											
	Basse			Intermédiaire			Élevée			Total		
Dépendance (nombre de critères	T	A	C	T	A	C	T	A	C	T	A	C
Nulle (0-2)	18	88	85	14	45	53	5	8	35	13	47	59
Faible (3-4)	28	8	11	30	22	21	22	12	34	27	14	18
Modérée (5-6)	34	3	2	39	15	14	51	19	23	40	12	13
Sévère (7-9)	19	1	3	17	17	12	23	61	17	20	27	10

T = tabac ; A = alcool ; C = cannabis

On observe une situation cohérente où le lien entre consommation élevée et dépendance est plus faible pour le cannabis que pour le tabac et l'alcool, et où, au total, la dépendance pour le cannabis est la plus faible des trois substances.

[90] Rigter, H. et M. van Laar (2002) «Epidemiological aspects of cannabis use. » in Pelc I., (ed.) *International Scientific Conference on Cannabis.* Bruxelles.

[91] Woody G.E. et coll., (1993) « Severity of dependence: Data from the DSM-IV field trials » *Addiction* 88, pages 1573-1579.

[92] Reproduit d'après INSERM (2001) *op. cit.*, page 73.

Le professeur Roques quant à lui, propose trois classes de produits en termes de leur dangerosité : la première comprend l'héroïne, la cocaïne et l'alcool ; la deuxième les psychostimulants, les hallucinogènes, le tabac, les benzodiazépines ; et le cannabis est en retrait dans une classe à part. Il classe la dangerosité des drogues selon un ensemble diversifié de critères. Nous reproduisons en page suivante son tableau de la dangerosité des drogues.

Notons en terminant qu'il n'y a pas de dépendance physique connue au cannabis, même si le sevrage dans les cas les plus sévères s'accompagnera parfois de manifestations physiques tels des tremblements, une insomnie, une irritabilité, etc.

Facteurs de dangerosité des « drogues » (reproduit de Roques, B. (1999), page : 296

	Héroïne	Cocaïne	MDMA	Psycho-stimulants	Alcool	Benzo-diazépines	Cannabi-noïdes	Tabac
Suractivation Dopami-nergique	+++	++++	+++	++++	+	±	+	+
Hypersensi-bilité à la dopamine	++	+++	?	+++	±	?	±	?
Activation du système opioïde	++++	++	?	+	++	+	±	±
Dépendance physique	très forte	faible	très faible	faible	très forte	moyenne	faible	forte
Dépendance psychique	très forte	forte mais intermittente	?	moyenne	très forte	forte	faible	très forte
Neurotoxi-cité	faible	forte	très forte (?)	forte	forte	0	0	0
Toxicité générale	forte	forte	éventuelle-ment très forte	forte	forte	très faible	très faible	très forte (cancer)
Dangerosité sociale	très forte	très forte	faible (?)	faible (exceptions)	forte	faible	faible	0
Traitements Substitutifs	oui	oui	non	non	oui	non recherché	non recherché	oui

La tolérance

De manière technique, la tolérance se définit comme suit :

> *« La propriété que possède l'organisme humain de supporter, sans manifester de réaction, l'administration de doses habituellement actives d'une substance déterminée. En matière de drogue, cette tolérance peut conduire à une augmentation des doses afin de retrouver l'effet recherché. »*[93]

Le développement d'une tolérance est associé à des modifications pharmacodynamiques. Dans certaines études animales, l'administration chronique de THC a réduit la densité des récepteurs dans certaines régions cérébrales[94], les augmentant dans d'autres ; ces effets seraient réversibles.[95]

Chez l'homme comme chez l'animal, les études observent un phénomène de tolérance au cannabis. Toutefois, les données doivent être interprétées avec prudence dans la mesure où certaines études et des cas cliniques ont aussi observé que les usagers réguliers avaient besoin de moins de cannabis pour atteindre l'effet recherché.[96] Néanmoins, une étude de Wiesbeck et coll sur 5611 sujets rapporte que 16 % des consommateurs fréquents de cannabis ont eu une histoire de syndrome de sevrage.[97]

C'est le phénomène de tolérance à la substance qui induit les symptômes de sevrage. Au cours des dernières années, les données cliniques sur le symptôme de sevrage chez les grands consommateurs de cannabis (plusieurs doses par jour de manière continue pendant plusieurs années) se sont accumulées. Les symptômes observés incluent l'agitation, la perte d'appétit, la nausée, les perturbations du sommeil, l'irritabilité ou l'hyperactivité et une augmentation de la température du corps.[98] Ces symptômes apparaissent après 24 heures d'abstinence, atteignent un pic après 2 à 4 jours et diminuent dans les 7 jours. Les symptômes sont nettement moins sévères et moins longs que pour les autres substances psychoactives. D'ailleurs, les études cliniques démontrent que la plupart des sujets continuent à mener leurs activités quotidiennes de manière normale.

---

93 OMS (1969), in Caballero et Bisiou (2000), *op. cit.*, page 6.

94 Rodriguez de Fonseca, F. et coll., (1994) « Downregulation of rat brain cannabinol binding sites after chronic delta-9-THC treatment », *Pharm. Biochem. Behav.* 47, pages 33-40.

95 Westlake, T.M. et coll., (1996) «Chronic exposure to delta-9-THC fails to irreversibly alter brain cannabinoid receptors » *Brain Research*, 544, pages 145-149.

96 Beardsley, R.M et coll., (1986) «Dependence on THC in rhesus monkeys», *Journal Pharmacol. Exp. Ther.*, 239 (2), pages 311-319.

97 Wiesbeck, G.A., et coll., (1996) « An evaluation of the history of a marijuana withdrawal syndrome in a large population. » *Addiction*, 91 (10), pages 1573-1579.

98 Kouri, E.M. et coll., (2000) «Abstinence symptoms during withdrawal from chronic marijuana use. » *Experimental and Clinical Psychopharmacology*, 8, pages 483-492.

Éléments de synthèse

Nous avons vu au chapitre 6 que les formes d'usage ne suivent pas un modèle unique, moins encore un modèle de progression du moins vers le plus. Même pour les usagers chroniques, la trajectoire d'usage est faite de pics et de creux, de périodes d'abstinence et de périodes de consommation intense. Nous avons vu aussi que les études épidémiologiques ne sont pas suffisamment sensibles pour tenir compte de l'interaction entre les multiples facteurs qui influencent les modèles de consommation. On comprendra que la conjonction de ces diverses difficultés rend difficile d'estimer la consommation problématique, plus encore la fréquence de la dépendance.

Il nous paraît cependant clair que le terme toxicomanie, déjà fortement critiqué, s'applique encore plus mal en ce qui concerne le cannabis. Avec ses référents physiologiques et ses relents moralistes, ce terme ne permet pas de saisir les comportements des usagers et par là d'informer adéquatement une politique publique axée sur la prévention et l'aide aux usagers ayant des problèmes. Il nous paraît clair aussi que la dépendance n'est que l'une parmi plusieurs conséquences de l'usage excessif et qu'en matière de cannabis elle ne doit pas être surestimée.

C'est pourquoi nous proposons de distinguer les usages en fonction de la conjonction d'au moins quatre facteurs : le contexte d'usage, la quantité consommée, la fréquence de l'usage ainsi que la durée et l'intensité.

Proposition de critères pour différencier les usages

	Contexte	Quantité	Fréquence	Durée et intensité
Expérimentation / Occasionnel	Curiosité	Variable	Quelques fois au cours de la vie	Aucune
Régulier	Récréatif, festif Surtout le soir Surtout en groupe	Quelques joints Moins d'un gramme par mois	Quelques fois par mois	S'échelonne sur quelques années mais rarement intensif
À risque	récréatif et occupationnel (pour aller à l'école, au travail, faire du sport…) Seul, le matin Moins de 16 ans	Entre 0,1 et 1 gramme par jour	Quelques fois par semaine, le soir, les fins de semaine surtout	S'échelonne sur plusieurs années avec des pics d'intensité élevée
Excessif	Occupationnel et problèmes personnels Usages dérégulés	Plus d'un gramme par jour	Plus d'une fois par jour	S'échelonne sur plusieurs années avec une intensité élevée continue pendant plusieurs mois à la fois

Tenant compte des limites de la base de connaissance épidémiologique, sur les tendances d'usage au Canada, nous sommes réduits à des estimations hautement spéculatives. Néanmoins, à titre indicatif, nous proposons les paramètres suivants :

- *Chez les adultes : nous avons estimé à environ 100 000 le nombre de personnes de plus de 18 ans qui consomment du cannabis quotidiennement,*
    - si on admet qu'entre 30 à 40 % d'entre eux consommeraient entre 0,1 et 1 gramme par jour, c'est dire qu'entre 30 000 à 40 000 seraient des usagers à risque ;
    - si on admet qu'entre 5 à 10 % consommeraient plus d'un gramme par jour, c'est dire qu'entre 5 000 et 10 000 adultes seraient des usagers excessifs.
- *Chez les jeunes de 12 à 17 ans, nous avons estimé qu'environ 225 000 feraient un usage quotidien.*
    - si on admet que tout usager de moins de 16 ans est usager excessif, et que les jeunes entre 12 et 15 ans qui consomment représentent environ 25 % des usagers de la classe d'âge des 12 – 17 ans, on peut estimer qu'environ 50 000 jeunes seraient usagers excessifs en raison de leur âge ;
    - si on estime que, du nombre restant soit environ 175 000 jeunes, environ 30 à 40 % consomment moins d'un gramme par jour, c'est donc environ 50 000 à 70 000 sont à risque ;
    - finalement, si entre 5 % et 10 % consomment plus d'un gramme par jour, c'est dire qu'entre 8 000 et 17 000 sont des usagers excessifs.

Nous sommes conscients que ces proportions ne tiennent pas compte des autres facteurs, notamment les contextes et la durée de l'usage. Nous ne pouvons que souhaiter que les enquêtes ultérieures que le Canada ne manquera pas de mener tenteront de mieux cerner la complexité des usages et la variabilité de leurs conséquences possibles.

CONCLUSIONS

Au total, sur la base de l'ensemble des données de recherche et des témoignages qu'il a entendus concernant les effets et conséquences de la consommation de cannabis **le Comité conclut que l'état des connaissances permet de penser que, pour la vaste majorité des usagers récréatifs, la consommation de cannabis ne présente pas des conséquences néfastes sur leur santé physique, psychologique ou sociale à court ou à long terme.**

De manière plus spécifique, cette conclusion s'appuie sur les conclusions suivantes :

	Conclusions du chapitre 7
Effets aigus du cannabis	➢ Les effets immédiats du cannabis se caractérisent par un sentiment d'euphorie, de détente, de sociabilité ; ils s'accompagnent d'une diminution de la mémoire à court terme, de la concentration et de certaines habiletés psychomotrices.
Distinctions entre les usages	➢ Aux fins de politique publique, le Comité ne considère pas utile les distinctions traditionnelles entre effets aigus et effets chroniques. ➢ De même, le Comité ne considère pas utile la dichotomie entre usage et dépendance. ➢ Les données de recherche ne permettent pas de distinguer clairement entre l'usage, l'usage à risque, et l'usage excessif. ➢ La quantité consommée est un indicateur, mais d'autres facteurs d'ordre psychosocial, et tenant au contexte d'usage et à la qualité de la substance, interviennent dans le passage de l'usage à l'usage à risque et à l'usage excessif.
Usage à risque et usage excessif chez les adultes	➢ Néanmoins, le Comité est d'avis que, pour les personnes de plus de 16 ans, l'usage à risque s'inscrit dans une fourchette entre 0,1 à 1gramme par jour sur une période prolongée et qu'au delà, il s'agit d'un usage excessif qui peut entraîner des conséquences négatives sur la santé physique, psychologique ou sociale des usagers. ➢ Selon cette distinction, et selon les données épidémiologiques présentées au chapitre précédent, il est permis de penser qu'environ 100 000 Canadiens de plus de 16 ans pourraient avoir un usage à risque et environ 80 000 pourraient avoir un usage excessif.
Tout usage chez les moins de 16 ans est un usage à risque	➢ Le Comité est d'avis qu'en raison de ses effets potentiels sur le système cannabinoïde endogène et les fonctions cognitives et psychosociales, toute consommation chez les jeunes de moins de 16 ans est une consommation à risque. ➢ Sur la base de nos estimations, ce seraient environ 50 000 jeunes. ➢ Chez les jeunes entre 16 ans et 18 ans, est consommation excessive une consommation même non quotidienne mais qui est faite le matin, seul ou pendant les activités scolaires.
Conséquences de l'usage excessif	➢ L'usage excessif de cannabis fumé peut avoir certaines conséquences négatives sur la santé physique, notamment sur le système respiratoire (bronchites chroniques, cancer des voies respiratoires supérieures). ➢ L'usage excessif de cannabis peut entraîner des conséquences psychologiques négatives sur les usagers, notamment des

	difficultés de concentration et d'apprentissage, ou, dans des cas rares et chez des personnes déjà prédisposées, déclencher des épisodes psychotiques ou schizophréniques. ➢ **L'usage excessif de cannabis peut entraîner des conséquences sur la santé sociale des usagers, notamment leur insertion professionnelle et sociale et leur capacité à accomplir des tâches.** ➢ **L'usage excessif de cannabis peut entraîner une dépendance qui demandera un traitement ; toutefois, la dépendance induite par le cannabis est moins sévère et moins fréquente que la dépendance à d'autres substances psychoactives y compris l'alcool et le tabac.**

CHAPITRE 8

CONDUITE SOUS L'EFFET DU CANNABIS[1]

« Stan Thompson avait 18 ans quand, avec quatre autres adolescents de Kanata, il a été tué dans un terrible accident de voiture à Perth un beau jour d'été. Un jeune a été jugé responsable de cet accident mortel et a purgé huit mois d'une peine de 12 mois de prison. La consommation de cannabis et la conduite en état d'ébriété étaient la cause de l'accident. (…) L'année de la mort de Stan, son père, Greg Thompson, est allé dans les écoles secondaires locales pour parler de l'accident, dire pourquoi les choses avaient mal tourné et comment la tragédie aurait pu être évitée. (…) Son message est que la consommation de marijuana affecte et affectera toujours les facultés de quelqu'un qui est au volant. Il a supplié les jeunes de ne pas le faire. (…) La marijuana n'est pas une substance bénigne. Il y a très peu de recherches qui pourraient permettre à quiconque de déterminer le niveau de l'incapacité liée à la marijuana et l'affaiblissement des facultés de ceux qui en fument et conduisent, et encore moins le degré d'incapacité à conduire lié à la consommation de marijuana et d'alcool. Nous avons vu dans le sondage effectué au Manitoba que plus de la moitié des jeunes qui consomment de la marijuana le font dans des automobiles et pendant les heures de classe. Il n'existe pas de moyen technique ou scientifique pour mesurer l'incapacité provoquée par la marijuana. Nous n'avons ni la technologie, ni les données scientifiques, ni la recherche nécessaire. Nous n'avons pas non plus la législation qu'il faudrait. Des études faites en Colombie-Britannique révèlent la présence de marijuana dans le corps de 12 à 14 % des conducteurs impliqués dans des accidents mortels. Le gouvernement du Québec et la Société de l'Assurance automobile du Québec effectuent actuellement des enquêtes en sécurité routière dans le cadre desquelles des volontaires soumettent des échantillons d'urine ou de sang. Les résultats de ces tests démontrent la présence de marijuana dans les échantillons prélevés sur 12 à 14 % de ces conducteurs. »[2]

S'il est une question, autre que les effets de la consommation de cannabis sur les jeunes ou des effets d'une consommation excessive, susceptible de préoccuper la société et les gouvernements, il s'agit certainement de ses effets sur la conduite d'un véhicule. On connaît déjà les effets sur la circulation routière de l'alcool avec sa cohorte d'accidents avec blessés ou tués. Malgré les diminutions constatées ces

[1] Hormis les études spécifiques que nous avons consultées et qui feront l'objet des renvois appropriés, ce chapitre s'inspire largement des recensions réalisées par l'INSERM (2001) *op. cit.*; Ramaekers et coll., (2001) pour la Conférence scientifique internationale sur le cannabis in Pelc, I., *op. cit.*, et de Smiley (1999) dans Kalant, H., (éd.), *op. cit.*

[2] R.G. Lesser, surintendant principal, gendarmerie royale du Canada, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 29 octobre 2001, fascicule no 8, page 17.

dernières années, il sera facile d'admettre qu'un accident mortel causé par la consommation d'une substance est déjà un accident de trop.

Or, après l'alcool, le cannabis est la substance psychoactive la plus consommée, notamment chez les jeunes du groupe d'âge 16-25. Occasionnelle, la consommation se produit le plus souvent dans un contexte festif, lors des parties de fin de semaine, souvent accompagnée aussi d'alcool. Les personnes de cette catégorie d'âge sont aussi les plus susceptibles d'avoir un accident automobile, et sont aussi susceptibles d'accidents avec facultés affaiblies.

Nous avons vu que le cannabis affecte les habiletés psychomotrices pour une durée pouvant aller jusqu'à cinq heures après la consommation. Les effets psychoactifs du cannabis sont aussi dépendants de la dose, de la concentration en THC, ainsi que de la morphologie, de l'expérience et des attentes des usagers. Mais quels sont les effets spécifiques du cannabis sur la conduite de véhicules ? Quels sont les effets de la combinaison d'alcool et de cannabis ? Et quels sont les outils permettant de détecter la présence d'un taux de THC susceptible d'affecter significativement les facultés psychomotrices reliées à l'opération de véhicules ?

Ici encore, les avis des témoins que le Comité a entendus divergent sur l'interprétation des résultats des études. Ainsi, l'association canadienne des policiers et policières nous a dit :

> *« La conduite automobile dans l'état de stupeur que provoque cette drogue réduit le jugement et la coordination motrice. Dans une étude portant sur des pilotes d'avion, dix pilotes brevetés, 24 heures après avoir fumé un joint contenant 19 mg de THC, soit une dose relativement légère, se sont soumis à des tests sur simulateur ; tous les dix ont fait des erreurs à l'atterrissage et l'un d'entre eux est passé complètement à côté de la piste. »*[3]

Deux semaines plus tard, le Dr John Morgan de la *City University of New York Medical School* disait au sujet de cette même étude :

> *« Un scientifique californien du nom de Jerome Yesevage en est l'auteur. C'est une étude qui remonte je crois au début des années 80 et qui avait à l'époque attiré l'attention. (…) L'étude du Pr Yesevage n'était régie par aucun paramètre de contrôle. (…) Comme vous l'avez entendu, l'utilisation de la marijuana est difficile à contrôler. Lorsque le Pr Yesevage a reçu une subvention du gouvernement fédéral américain pour répéter l'étude mais en y ajoutant les paramètres de contrôle simples que j'avais préconisés, comme d'autres d'ailleurs, il n'a pas réussi à démontrer un quelconque effet de la marijuana après quatre heures dans un groupe témoin similaire. Par conséquent, je pense qu'en réalité, le fait de fumer de la marijuana a effectivement une incidence lors de tests conduits dans des simulateurs de*

[3] Dale Orban, sergent-détective, Service de police de Regina, pour l'Association canadienne des policiers et policières, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 28 mai 2001, fascicule no 3, page 47.

pilotage, et également, dans une certaine mesure, sur les réflexes au volant, pendant un maximum de trois à quatre heures après le fait, mais ces effets ne durent pas, en plus ils sont relativement faibles. »[4]

Référant ensuite aux travaux de Robbe que nous examinons plus en détail dans ce chapitre, le professeur Morgan ajoutait :

> *« Un scientifique hollandais qui, pendant plusieurs années, a fait des expériences sur la conduite automobile a constaté que les conducteurs qui fumaient de la marijuana avaient quelques difficultés à rester dans leur bande de circulation. C'est ce test qui est le plus révélateur. Si vous fumez de la marijuana, vous aurez tendance à zigzaguer un peu plus que quelqu'un qui est tout à fait sobre. C'est important certes, même si aucune étude n'a démontré que ce zigzaguage avait une influence significative sur les facultés du conducteur.*
> *Le scientifique hollandais en question a ajouté dans son rapport que ce phénomène (...) était relativement le même que chez les conducteurs qui avaient consommé de l'alcool en petites quantités, qui avaient pris de la benzodiazépine en petites quantités, ou encore des antihistaminiques à faibles doses. »*[5]

Or, le même jour, le professeur Kalant, de l'Université de Toronto, répondait ce qui suit :

> *« Le Dr Morgan a parlé de certaines études expérimentales ce matin. Un certain nombre d'études, recensées par le Dr Smiley dans le rapport du Comité sur les effets du cannabis sur la santé de l'Organisation mondiale de la santé démontre un certain degré d'entente sur ce que sont les principaux effets sur la conduite automobile. Comme le Dr Morgan l'a dit, le conducteur a du mal à rester dans sa voie. Il ne manipule pas le volant avec autant de précision. Le temps de démarrage et le temps de freinage ralentissent. La recherche à vue est réduite. Autrement dit, lorsqu'on conduit, on doit être à l'affût des sources de danger des deux côtés et pas seulement devant soi. On note une baisse de la surveillance et une moins grande reconnaissance des signaux de danger. Les effets sont synergiques avec ceux de l'alcool. La seule chose favorable à propos du cannabis par rapport à l'alcool, c'est que les fumeurs de cannabis sont moins agressifs que les buveurs, de sorte qu'ils risquent moins de doubler dangereusement ou de faire de la vitesse. Il reste néanmoins que la capacité de conduite est altérée non seulement par une moins bonne direction mais aussi par une moins grande vigilance face à l'imprévu et aux sources de danger.*
> *Je ne vais pas parler des statistiques sur le terrain concernant le rôle du cannabis dans les accidents de la route. Toutefois, je voudrais dire qu'un certain nombre d'études ont démontré des signes de la présence du cannabis dans le sang et l'urine de gens arrêtés pour conduite avec facultés affaiblies en l'absence d'alcool. »*[6]

---

[4] Dr John Morgan, professeur à la City University of New York Medical School, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 11 juin 2001, fascicule no 4, page 40-41.

[5] *Ibid.*

[6] Dr Harold Kalant, professeur émérite à l'Université de Toronto, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 11 juin 2001, fascicule 4, page 75.

Comme on le voit, et comme c'était le cas pour les effets et conséquences sur la santé des usagers, les avis divergent sur l'interprétation des études et leur signification quant aux effets spécifiques de la marijuana sur la conduite de véhicules.

Ce chapitre se divise en trois sections. La première examine les modes de dépistage de la présence de cannabinoïdes dans l'organisme. La seconde analyse les études sur la prévalence connue de conduite sous l'influence de véhicules, hors contexte accidentel et en contexte accidentel. Enfin la troisième résume l'état des connaissances sur les effets du cannabis sur la conduite de véhicules à partir d'études *in situ* ou en laboratoire. Comme pour les autres chapitres, le Comité dégagera ensuite ses propres conclusions.

MODES DE DÉPISTAGE

On connait cinq milieux de dépistage de la présence de cannabinoïdes dans l'organisme : le sang, l'urine, la salive, les cheveux et la sueur.

Le sang est le milieu le plus approprié pour détecter la consommation récente de cannabis, puisque seule l'analyse du sang permet de distinguer entre les principes actifs du cannabis et les métabolites dépourvus d'effets psychoactifs. Toutefois, comme nous l'avons déjà vu, les concentrations de Δ^9THC dans le sang atteignent un pic 9 minutes après la consommation de la cigarette, après 10 minutes il n'en reste que les deux tiers, 5 à 10 % au bout d'une heure et après deux heures, il sera à la limite de la détection. Il s'ensuit que toutes les méthodes ne sont pas appropriées pour le dépistage en raison de la forte possibilité de produire des faux négatifs et des faux positifs. La méthode la plus fiable, la chromatographie en phase gazeuse avec détection par spectrométrie de masse a une excellente sensibilité et permet également d'estimer le temps écoulé entre le moment de la dernière consommation et la prise de sang.

L'on a vu au chapitre 7 qu'il y a une relation dose-effet : 25 bouffées affectent les facultés cognitives de façon plus nette que 10 bouffées et 10 que 4. Mais il existe peu de données sur la relation entre la concentration et les effets sur la personne et la capacité notamment à répondre à la question centrale en matière de sécurité routière : à partir de quelle concentration peut-on considérer que les facultés étaient réduites ? En France, le seuil de positivité du Δ^9THC a été fixé à 1ng/ml[7] pour les conducteurs impliqués dans des accidents mortels. Un autre auteur a proposé une formule établissant un rapport entre le Δ^9THC, le 11-OH Δ^9THC et le Δ^9THC -COOH pour déterminer un facteur d'influence du cannabis avec un seuil de positivité de 10 ng/ml. Une concentration égale de Δ^9THC et de COOH suggérerait une consommation remontant à environ 30 minutes et donc une forte probabilité d'effets

[7] Dans ce chapitre, ng signifie nanogramme (soit un milliardième de gramme) et µg signifie microgramme (soit 1 millionième de gramme).

psychoactifs tandis qu'une concentration plus élevée de COOH que de Δ^9THC suggère que la consommation remonterait à plus de 40 minutes. Cependant, une concentration de COOH de plus de 40 µg/l indiquerait qu'il s'agit d'un consommateur chronique pour lequel il devient alors impossible de déterminer à quand remonterait la dernière consommation. D'autres travaux établissent qu'une concentration de 10 à 15 ng/ml dans le sang suggère une consommation récente sans que l'on puisse cependant établir à quand elle remonte.[8]

Les urines sont aussi un milieu de dépistage fréquemment utilisé et demeurent le milieu le plus approprié pour un dépistage rapide de la consommation. Par contre, les urines peuvent conserver des traces de consommation de cannabis pendant des semaines. De surcroît, ces traces sont celles du Δ^9THC-COOH, un métabolite inactif. Par conséquent, leur intérêt tient principalement à des mesures épidémiologiques de la consommation de cannabis et ne contribue pas à la connaissance de la conduite avec facultés affaiblies.

Les niveaux de concentration du Δ^9THC-COOH dans les urines sont très élevés : pour un usager d'un joint par jour elles se situent entre 50 et 500 ng/ml et peuvent atteindre plusieurs milliers de ng/ml chez les gros consommateurs, le seuil de positivité actuellement recommandé étant de 50 ng/ml d'urine.

La salive est un milieu très prometteur pour la sécurité routière parce que non intrusive et capable d'indiquer avec une certaine précision une consommation récente. La présence de Δ^9THC dans la salive est essentiellement due au phénomène de séquestration bucco-dentaire lors de l'inhalation. Les concentrations y sont très élevées dans les minutes suivant l'absorption, variant entre 50 et 1 000 ng/ml, mais déclinent ensuite très rapidement dans les heures qui suivent, restant détectables pendant 4 à 6 heures en moyenne. Le projet européen ROSITA a comparé la fiabilité des prélèvements dans les urines, la sueur et la salive par rapport au sang. La salive est de loin le milieu le plus fiable, démontrant une corrélation exacte dans 91 % des cas. Toutefois, son faible niveau de concentration pendant la majeure partie de la durée des effets psychoactifs signifie qu'elle exige une méthode analytique sensible. Il n'existe malheureusement pas encore d'outil rapide de détection suffisamment performant et fiable en situation de conduite. Ainsi, les outils de détection en situation de conduite n'identifiaient correctement que 18 à 25 % des cas et produisaient beaucoup de faux négatifs.[9]

La sueur est généralement reconnue comme un mauvais milieu de détection, notamment en raison de la persistance du Δ^9THC dans ce milieu, en même temps qu'il est excrété dans la sueur en faible quantité.

---

[8] INSERM (2001), *op. cit.*, : pages 152-153.

[9] Ramaekers, J.G. et coll., (2002) « Performance impairment and risk of motor vehicle crashes after cannabis use » in Pelc, I. (éd.) *International Scientific Conference on Cannabis*, Bruxelles, page : 81.

Enfin, les cheveux sont un milieu particulièrement intéressant puisqu'il s'y retrouve une quantité significative de Δ^9THC qui permet d'établir la chronicité et le niveau (faible, moyen, élevé) de consommation. Toutefois, les concentrations sont de quelques ng par mg de cheveux, ce qui exige des analyses très performantes.

Le tableau suivant, tiré du rapport de l'INSERM, résume les principales caractéristiques des divers milieux biologiques de dépistage ; nous y avons ajouté, lorsque disponible, le seuil de détection retenu.

Principales caractéristiques des milieux biologiques de dépistage

	Cannabinoïdes majoritaires	Délai maximum de détection	Domaine d'intérêt	Méthodologies disponibles	Seuil de positivité
Urines	THC-COOH (inactif)	Consommation occasionnelle : 2 à 7 jours Consommation régulière : 7 à 21 jours	Dépistage d'une consommation	Oui ; nombreux tests rapides	50ng de Δ^9THC-COOH par ml
Salive	THC (actif)	2 à 10 heures	Dépistage d'une consommation récente	Non, pas de tests rapides	non déterminé
Sueur	THC	Très variable	Peu d'intérêt	Non, pas de tests rapides	inutile
Cheveux	THC	Infini	Révélation et suivi d'un usager régulier	Oui ; CPG-SM	non déterminé
Sang	THC 11-OH THC THC-COOH	2 à 10 heures	Confirmation, identification, dosage	Oui ; CPG-SM	1ng/ml (France)

Dans tous les cas, la manipulation et le transport des échantillons ainsi que les dosages toxicologiques sont essentiels à la qualité des analyses.

Par ailleurs, on constate qu'il existe encore beaucoup d'incertitudes sur les seuils permettant d'affirmer que la présence de Δ^9THC affectait les facultés du conducteur. De surcroît, il n'existe pas encore de test de dépistage rapide fiable permettant d'identifier une consommation récente (ce que les tests d'urines ne peuvent faire). Enfin, d'autres drogues que l'alcool, dont plusieurs médicaments prescrits, peuvent avoir un impact sur la conduite de véhicules. C'est pourquoi plusieurs auteurs, et certains témoins, nous ont suggéré que le Canada devrait adopter le programme de classification et d'évaluation des drogues (DEC) et reconnaître les policiers formés à la reconnaissance des drogues (*Drug Recognition Expert*). Cette pratique est maintenant en

place dans la plupart des États américains (au moins 34 de même que le District de Columbia), en Colombie-Britannique, en Australie, en Norvège et en Suède.

Le scénario typique de conduite sous l'influence de substance psychoactives autres que l'alcool est le suivant : un véhicule attire l'attention du policier ; celui-ci immobilise le véhicule et interroge le conducteur ; s'il a des motifs suffisants de croire que le conducteur est intoxiqué, il lui fait passer un test d'alcoolémie ; toutefois, lorsque ce test donne un résultat inférieur à la limite légale, le policier peut ne pas être convaincu que le conducteur est en état de conduire, mais comment le démontrer ? Auparavant, il était le plus souvent obligé de le relâcher. Comme nous venons de le voir, il n'existe pas, en matière de drogues et de médicaments, d'équivalent au test d'alcoolémie et, en matière de cannabis notamment, des traces dans les urines n'établissent nullement que la consommation est récente. C'est dans ce contexte que les policiers du service de police de la Ville de Los Angeles ont développé, au début des années 1980, le *Drug Recognition Expert System* (DRE). Ces policiers reçoivent une formation spécifique sur la détection de la conduite sous l'influence de substances psychoactives et l'emploi du DEC.

Ce système permet au policier qui a des raisons de croire que le conducteur est intoxiqué de faire appel à un officier spécialement formé à la reconnaissance des drogues. Celui-ci procédera alors à l'évaluation du conducteur à partir d'un ensemble systématique et rigoureux de facteurs reconnus comme signalant la présence de drogues. Le processus inclut douze étapes :

- Test d'alcoolémie : Cet examen aura été fait au préalable par le policier qui a procédé à l'interpellation du véhicule. L'agent formé à la reconnaissance des drogues ne sera appelé que lorsque le test est négatif ;
- Interrogation du policier qui a procédé à l'interpellation : L'agent pose une série de questions conventionnelles au policier : dans quelle condition il a trouvé le suspect, ce qu'il avait observé, s'il a trouvé des drogues dans le véhicule, les déclarations du suspect, etc. ;
- Examen préliminaire (premier des trois mesures du rythme cardiaque) : Il s'agit ici de déterminer s'il y a des motifs suffisants de soupçonner la présence de drogues, et donc d'éliminer la possibilité qu'il s'agisse d'une condition médicale. L'agent observe l'état général du suspect, l'interroge sur sa condition de santé, procède à un examen des pupilles et du regard, et prend la première des trois mesures du rythme cardiaque. S'il estime qu'il n'y a aucun signe, le suspect sera relâché. S'il s'agit d'une condition d'ordre médical, il fera demande d'une évaluation médicale. Mais s'il pense qu'il s'agit de drogues, il poursuit alors l'examen ;
- Examen des yeux : L'agent procède à trois examens : un examen du regard vertical, du regard horizontal, et de la convergence. Il semble qu'aucune drogue ne soit capable d'entraîner un mouvement involontaire sautillant des pupilles sur l'axe vertical sans d'abord l'avoir provoqué sur l'axe horizontal. Aussi, s'il n'y a qu'un tremblement vertical, il s'agit probablement d'une

condition médicale (par exemple des lésions cérébrales). S'il y a tremblement horizontal, il est probable qu'il s'agit de drogues. Pour constater le tremblement horizontal, l'agent promène un stylo ou un autre objet sur un plan horizontal devant les yeux du suspect. Pour le tremblement vertical, il le promène de haut en bas. Enfin, certaines drogues empêchant les yeux de loucher, l'agent procédera à un test de convergence en plaçant le stylo ou l'objet sur le nez de la personne et lui demandant de le regarder ;

- Tests d'attention divisée : tâches incluant des tests d'équilibre, de marche, de se tenir sur une jambe et de porter son doigt au nez ;
- Examen des signes vitaux : seconde des trois mesures du rythme cardiaque, de la pression et de la température du corps ;
- Examen des pupilles sous quatre conditions différentes : lumière de la pièce, noirceur, lumière indirecte et lumière directe;
- Tonus musculaire : mouvements des bras ;
- Examen de sites possibles d'injection ;
- Interrogation sur la consommation de drogues et les habitudes de vie ;
- Opinion : sur la base de l'ensemble de ces observations, l'agent se forme une opinion qui doit reposer sur un degré raisonnable de certitude ;
- Examen toxicologique : cet examen vise à corroborer l'analyse faite par l'agent. La décision de poursuite ne sera prise que sur réception des analyses.

Ce système a fait l'objet d'une standardisation au début des années 1980 avec le concours de l'administration nationale de la circulation routière aux États-Unis. Il a d'abord été validé dans une étude en laboratoire. [10] Dans cette étude, quatre agents formés à la reconnaissance des drogues ont évalué des sujets qui recevaient soit un placebo soit une dose de drogue. Ni les sujets, ni les agents ne savaient qui avait reçu la drogue. Dans 95 % des cas, les agents ont identifié correctement les sujets qui n'avaient pas reçu de drogue. Dans 97 % des cas, ils ont identifié correctement les sujets qui avaient reçu de drogues et dans 98,7 % des cas ils ont pu déterminer quels sujets étaient sous l'influence de drogue.

Une étude en situation réelle a ensuite été menée en 1985, toujours avec le concours de l'administration de la circulation routière.[11] Dans cette étude, des échantillons de sang de 173 conducteurs arrêtés pour conduite sous l'influence de drogues ont été analysés par un laboratoire indépendant. Cette étude a démontré que les analyses des agents formés à la reconnaissance avaient prédit correctement dans 94 % des cas la présence de drogues autres que l'alcool. Dans 79 % des cas, les

---

[10] Bigelow, G.E. (1985) *Identifying types of drug intoxication laboratory evaluation of a subject procedure.* Cité dans Sandler, D. (2000) « Expert and Opinion Testimony of Law Enforcement Officers Regarding Identification of Drug Impaired Drivers. » *University of Hawai'i Law Review* 23 (1) : 150-181.

[11] Compton, P.R. (1986) *Field Evaluation of the Los Angeles Police Department Drugs Detection Procedure.* Cité dans Sandler, D., *op. cit.*, page : 151.

analyses des agents identifiant la présence d'une drogue en particulier s'étaient révélées justes.

L'étude la plus complète a été menée en 1994 en Arizona. Dans cette étude, les dossiers de plus de 500 personnes arrêtées pour conduite sous l'influence de drogues ont été analysés et des analyses toxicologiques menées. L'étude a démontré que les analyses toxicologiques ont corroboré les conclusions des agents dans 83,5 % des cas. Des études semblables menées dans d'autres états ont donné des résultats comparables : 81,3 % au Texas, 84,5 % au Minnesota, 88,2 % en Californie, 88,2 % à Hawaii et 88 % en Oregon.

En ce qui concerne spécifiquement le cannabis, les indicateurs attendus dans ce système sont généralement les suivants : pas de tremblement horizontal ni vertical mais non-convergence du regard, pupilles dilatées, pouls accéléré et tension élevée.

En somme, tenant compte des limites à la détection sur site de l'influence du cannabis et des résultats de ces études, **il semble que l'adoption du DEC et la formation des policiers à la reconnaissance de la présence de drogues serait hautement souhaitable**.

DONNÉES ÉPIDÉMIOLOGIQUES

Selon certains témoins que nous avons entendus, la proportion de personnes conduisant avec facultés affaiblies et qui sont sous l'influence du cannabis dépasserait les 40 %. D'autres ont précisé qu'environ 12 % des accidents avec blessés pouvaient être attribués à la consommation de cannabis. Que révèlent les études ?

Les données sur la fréquence de conduite sous influence de cannabis (seul ou avec d'autres substances) sont, pour des raisons évidentes, difficiles à obtenir. Premièrement, pour les conducteurs accidentés, un test d'alcoolémie positif signifie la plupart du temps qu'aucune autre mesure ne sera faite, le niveau d'alcool dans le sang supérieur à la limite légale suffisant pour entreprendre des poursuites légales. Ensuite, les moyens de détection de la présence de THC sont intrusifs (sang, urine) contrairement à la détection éthylique, et posent donc des problèmes juridiques et éthiques spécifiques. D'autres mesures, tels les prélèvements de salive, ne permettent pas, pour le moment, un enregistrement sur détection à partir de sites routiers. Enfin, lors d'études sur l'ensemble des conducteurs, le consentement des conducteurs est essentiel au prélèvement sanguin ou urinaire, limitant ainsi la généralisabilité des résultats. Néanmoins, un certain nombre d'études ont été menées ces dernières années dont nous résumons les grandes lignes.

Études hors contexte accidentel

Deux types d'études ont été menées : des enquêtes sur l'ensemble des conducteurs pris au hasard dans le flot routier à divers moments de la journée et de la semaine, et des études sur présomption de conduite sous influence à l'occasion de contrôles policiers. Le tableau suivant, tiré de l'expertise collective de l'INSERM, résume ces données.

Détection et prévalence du cannabis en Europe et au Québec hors contexte accidentel[12]

Pays / Référence	Population	Méthode de détection	Echantillon	Prévalence (%)
Hors présomption de conduite sous influence de substances psychoactives				
Allemagne, Kruger et coll., 1995	Ensemble des conducteurs	Dépistage : FPIA salive Confirmation : CG/SM salive	2 234 (sur 3 027)	0,6
Pays-Bas, Mathtijssen, 1998	Conducteurs les nuits de week-end	Dépistage : test salive, sueur et urine simultanément	293 (sur 402)	5
Italie, Zancanner et coll., 1995	Conducteurs les nuits de week-end	Dépistage clinique, vérification clinique et toxicologique (sang, urine)	1 237	1,5
Canada Dussault et coll, 2000	Conducteurs sur route (enquête représentative)	Urine Salive Air expiré (alcool)	2 281 2 260 5 281	5 (en cours) > 0,8 : 0,8
Avec présomption de conduite sous influence de substances psychoactives				
Norvège, Skurtveit et coll., 1996	Conducteurs	Dépistage : immuno-essai sang ; Confirmation : CG/SM sang	2 529	26
Danemark, Worm et Steentoft, 1996	Conducteurs	Dépistage : RIA sang Confirmation : CG/SM sang	317 221	10 17
Royaume-Uni, Écosse, Seymour et Oliver, 1999	Conducteurs	Dépistage : immuno-essai sang ; Confirmation CG/SM sang	640	26

Au total, on observe que les taux de détection de la présence de cannabis varient entre 1 % et 5 % hors présomption de conduite avec facultés affaiblies. Toutefois, les données manquantes, vraisemblablement pour refus de fournir un prélèvement, empêchent de tirer des conclusions claires. Quant aux études avec présomption de conduite sous l'influence de drogues, les résultats sont nettement plus élevés : entre 10 et 26 %. Ces résultats ne traduisent pas nécessairement une prévalence plus élevée

[12] Tableau reproduit de INSERM (2001), *op. cit.*, page 175.

de conduite sous l'influence de substances psychoactives, mais plutôt une plus grande vigilance des policiers. En effet, comme on le verra immédiatement, la prévalence de détection de cannabis lors d'accidents mortels n'est pas plus élevée en Norvège (7,5 %) que dans les autres pays.

Études en contexte accidentel

Le tableau suivant, adapté de l'INSERM, présente les résultats d'un certain nombre d'études récentes en Europe, en Amérique et en Australie.

Prévalence de la conduite sous influence (csi) en contexte accidentel [13]

Pays	Population	Méthode de détection	Echantillon	Prévalence cannabis (%)
Belgique Meulemans et coll, 1997	Accidents corporels (2 roues et voitures)	Dépistage : urine Confirmation : urine CG/SM et comparaison urine sang	1 879	6 (urine) 3,6 (sang)
Espagne Alvarez et coll, 1997	Tués dans des accidents et soupçonnés de csi	Dépistage : immuno-essai sang Confirmation : CG/SM sang	979	1,5 peu fiable
France, Mura et coll., 2001	Accidents corporels (groupe témoin : patients)	Sans dépistage Confirmation : CG/SM sang	420 (381)	11,2 (10,8)
France, Kintz et coll, 2000	Accidents corporels	Dépistage : urine Confirmation : CG/SM urine et sang, tests salive et sueur	198	13,6 (urine) 9,6 (sang)
Italie, Ferrara, 1990	Blessés Contrôle vendredi soir	Dépistage : EMIT urine	4 350 500	5,5
Norvège, Christophersen, 1995	Blessés, accidents non mortels	Dépistage : immuno-essai sang Confirmation : CG/SM sang	394	7,5
Royaume-Uni, Tunbridge, 2000	Accidents mortels (dont 516 conducteurs)	Dépistage : immuno-essai urine Confirmation : CG/SM sang	1 138 516	12 10
Australie, Longo, 2000	Blessés (accidents non mortels)	Dépistage : immuno-essai sang Confirmation : CG/SM sang	2 500	11
Canada, Cimburra, 1990	Tués		1 169	11
États-Unis, Logan, 1996	Tués		347	11

[13] Adapté de INSERM (2001), *op. cit.*, pages 171 et 174.

Il est difficile de comparer les études entre pays puisque les méthodes de détection, même en contexte accidentel, varient largement d'un pays à l'autre. Soulignons aussi à nouveau que le fait de dépister du cannabis chez les conducteurs accidentés n'est pas nécessairement signe qu'il en était la cause. Non plus que l'absence d'un dépistage ne signifie qu'il n'y avait pas conduite sous l'influence de cannabis.

Trois de ces études sont particulièrement intéressantes. L'étude de Mura et coll. (2001) montre une différence significative selon l'âge des conducteurs : chez les 18-20 ans, le Δ^9THC était présent chez 18,6 % des conducteurs, et dans 50 % des cas il était présent seul (sans alcool). Une étude antérieure de Mura (1999) avait démontré que le cannabis était particulièrement présent chez les jeunes conducteurs : de 35 % à 43 % chez les moins de 30 ans, avec une prévalence encore plus forte (43 %) chez les moins de 20 ans, tandis qu'au-delà de 35 ans la prévalence tombe à 3 %.[14]

L'étude de Kintz et coll (2000) est intéressante notamment parce qu'elle montre clairement qu'après l'alcool (13,6 %) le cannabis est le produit le plus présent chez les conducteurs accidentés (9,6 %). Cette étude révèle aussi que sur l'ensemble de l'échantillon, l'incidence du cannabis mesuré par prélèvement sanguin (9,6 %) se rapproche de l'incidence de la conduite sous l'influence de l'alcool (10,6 %).[15]

Enfin, l'étude de Longo est d'un intérêt particulier en raison de la taille de l'échantillon, de sa représentativité et de la distinction entre les analyses de Δ^9THC et de Δ^9THC-COOH. Cette étude a détecté la présence de cannabinoïdes chez 10,8 % des conducteurs : 8 % pour le Δ^9THC-COOH seul et 2,8 % pour le Δ^9THC-COOH et le Δ^9THC ensemble, révélant ainsi un pourcentage plus faible de Δ^9THC positifs que dans les autres études. Par ailleurs, comme dans les autres études, les sujets positifs au Δ^9THC étaient plus jeunes et plutôt des hommes.

Plus près de nous, Mercer et Jeffery ont examiné les analyses toxicologiques des 227 conducteurs tués lors d'accidents de la circulation en Colombie-Britannique entre octobre 1990 et septembre 1991.[16] Les prélèvements étaient faits à l'autopsie dans les 24 heures suivant le décès ce qui, selon les auteurs, peut indiquer une sous-estimation de la présence d'alcool ou de drogues. Sur les 227 tués, 186 (43 %) n'avaient ni alcool ni drogues, 83 (37 %) avaient seulement l'alcool, 23 (11 %) avaient alcool et drogues, et 21 étaient négatifs pour l'alcool et positifs pour les drogues. En ce qui concerne le cannabis, 29 tués (13 % ; 26 hommes et 3 femmes) étaient Δ^9THC-COOH positifs, enregistrant en moyenne une concentration de 15,9 ng/ml. Parmi le groupe +alcool/+drogues, (23 sujets), 17 étaient positifs aux métabolites du THC et 8 d'entre eux étaient positifs au Δ^9THC (13 %). Pour le groupe 0alcool/+drogues (21 sujets), 8 (tous des hommes) étaient positifs au Δ^9THC –COOH dont 4 au Δ^9THC. Même si

[14] Voir INSERM, (2001), *op. cit.*, page 172.

[15] *Ibid.*

[16] Mercer, W.G. et W.K. Jeffery (1995) « Alcohol, Drugs and Impairment in Fatal Traffic Accidents in British Columbia » *Accid. Anal. And Prev.*, 27 (3) : 335-343.

les auteurs concluent que le Δ^9THC /Δ^9THC-COOH était présent dans 13 % des cas, soit une proportion comparable à la plupart des autres études, il faut observer que seuls 12 sujets tués étaient positifs au Δ^9THC avec ou sans alcool et 4 seulement sans alcool.

Finalement, une étude épidémiologique plus récente portait sur les 1158 cas d'accidents mortels (391) ou de cas de conduites sous l'influence de substances psychoactives lorsque le taux d'alcoolémie était inférieur à 0,1 (767) rapportés aux laboratoires de toxicologie pénale du Canada au 12 novembre 1994.[17] Les substances les plus fréquentes étaient les benzodiazépines (590 cas), l'alcool (580), le cannabis (551), les stimulants (224), les opiacées (176) et les barbituriques (131). Pour le cannabis, on obtient le tableau suivant :

Présence de cannabis au Canada (1994)

	Total	Avec alcool	Sans alcool
THC			
➢ **conduite sous influence**	181	129	52
➢ **décès**	198	98	100
THC-COOH			
➢ **conduite sous influence**	127	29	98
➢ **décès**	45	24	21

Au total, les cas où le Δ^9THC sans alcool était présent représentent 13 % du total, un pourcentage qui se rapproche de celui que l'on constate dans les autres études.

Sur l'ensemble de ces études, on constate que la présence de cannabis chez les conducteurs accidentés ou tués varie entre 3,6 % (confirmé par une analyse du sang) et 13 % (sans confirmation). Lorsqu'il y a confirmation pour la présence de Δ^9THC par rapport au Δ^9THC-COOH, la présence du principe actif diminue de moitié. D'autre part, les jeunes hommes ont des risques beaucoup plus élevés que les autres conducteurs de tester positif. Ces conclusions sont aussi largement partagées par d'autres auteurs.[18]

[17] Jeffery, W.K. et coll. (1996) « The involvement of drugs in driving in Canada : An update to 1994. » *Can. Soc. Forens. Sci. J.*, 29 (2) pages 93-98.
[18] Notamment le rapport de l'INSERM (2001), *op. cit.* ; Ramaekers, J.G. et coll., (2002) « Performance impairment and risk of motor vehicle crashes after cannabis use » in Pelc, I. (ed.) *International Scientific Conference on Cannabis*, Bruxelles.

Enquêtes épidémiologiques auprès des jeunes

Certaines enquêtes épidémiologiques menées auprès des jeunes en milieu scolaire ont commencé au cours des dernières années à leur poser des questions sur la fréquence de conduite sous l'influence de substances psychoactives, l'alcool et le cannabis en particulier. En Ontario, l'enquête OSDUS dont il a été question au chapitre 6, démontre que, pour 2002, 19,3 % des étudiants disaient avoir conduit un véhicule une heure ou moins après avoir consommé du cannabis au moins une fois au cours des douze derniers mois.[19] De manière intéressante, 15 % disaient avoir conduit un véhicule moins d'une heure après avoir pris deux consommations ou plus d'alcool. Par ailleurs, l'enquête en milieu scolaire auprès des jeunes au Manitoba indique que près de 20 % d'entre eux ne voient rien de mal à consommer du cannabis et à conduire.[20]

Notons enfin les données de l'étude de Cohen et Kaal auprès de consommateurs au long cours qui démontrait que pas moins de 42 % des répondants à Amsterdam et 74 % à San Francisco déclaraient avoir déjà conduit un véhicule sous l'influence du cannabis.[21]

Évaluation du risque

Tenant compte des difficultés de mener des études épidémiologiques fiables sur la conduite sous influence de cannabis, un certain nombre d'auteurs ont analysé la probabilité de responsabilité et le ratio de risque attaché à la consommation de cannabis. Ces études distinguent entre les conducteurs responsables et non responsables des accidents. Les premiers sont les sujets et les seconds le groupe témoin. L'on procède ensuite à des comparaisons de leur intoxication à diverses substances. Évidemment, la décision de classement selon l'axe responsable/non responsable peut dépendre de la perception qu'aura l'enquêteur de la présence ou non de substances psychoactives.

Le tableau suivant, reproduit du rapport produit par Ramaekers et coll. (2002) pour la conférence scientifique internationale sur le cannabis résume les résultats de diverses études.[22] Signalons que la probabilité de responsabilité des conducteurs présentant des traces de cannabis (Δ^9THC et/ou Δ^9THC –COOH, mesuré dans le sang ou l'urine) est comparée à celle des conducteurs accidentés sans aucune substance (y compris l'alcool). Le ratio de risque des conducteurs sans substance est de 1,0 et sert de point de comparaison pour déterminer la signification statistique du changement

---

[19] Adlaf, E.M. et A. Paglia (2001) *Drug Use among Ontario Students 1997-2001. Findings from the OSDUS.* Toronto : Centre for Addiction and Mental Health, page 134.

[20] Patten, D., et coll., (2000) *Substance Use among High School Students in Manitoba.* Winnipeg : Addictions Foundation of Manitoba.

[21] Cohen, P.D.A. et H.L. Kaal (2001) *The Irrelevance of Drug Policy. Patterns and careers of experienced cannabis use in the populations of Amsterdam, San Francisco and Bremen.* Amsterdam : University of Amsterdam, CEDRO, page 68.

[22] Ramaekers et coll. (2002), *op. cit.*., page 73.

observé du risque des conducteurs sous influence. Lorsque la valeur référence se situe au delà du niveau de confiance statistique de 95 %, il est permis de penser que cette drogue est à 95 % associée à un risque de responsabilité accru.

Ratio de culpabilité relatif à la conduite sous l'influence du cannabis

Auteurs	Substances	ratio	Intervalle de confiance à 95%	Conducteurs coupables/non coupables
Terhune & Fell (1982), É.U.	Sans substances	1,0		94/179
	Alcool	5,4*	2,8 – 10,5	45/16
	THC	2,1	0,7 – 6,6	9/8
	Alcool/THC	-		-
Williams et coll. (1985), É.U.	Sans substances	1,0		55/23
	Alcool	5,0	2,1 – 12,2	120/10
	THC ou THC-COOH	0,2	0,2 – 1,5	10/9
	Alcool/THC ou THC-COOH	8,6*	3,1 – 26,9	123/6
Terhune et coll. (1992), É.U.	Sans substances	1,0		541/258
	Alcool	7,4*	5,1 – 10,7	587/38
	THC	0,7	0,2 – 1,8	11/8
	Alcool/THC	8,4*	2,1 – 72,1	35/2
Drummer (1994), Australie	Sans substances	1,0		392/140
	Alcool	5,5*	3,2 – 9,6	261/17
	THC-COOH	0,7	0,4 – 1,5	29/14
	Alcool/THC-COOH	5,3*	1,9 – 20,3	59/9
Hunter et coll. (1998), Australie	Sans substances	1,0		944/821
	Alcool	6,8*	4,3 – 11,1	173/22
	THC			
	➢ **≤ 1.0 ng/ml**	0,35	0,3 – 2,1	2/5
	➢ **1,1 – 2,0 ng/ml**	0,51	0,2 – 1,4	7/12
	➢ **> 2 ng/ml**	1,74	0,6 – 5,7	12/6
	THC-COOH			
	➢ **1 – 10 ng/ml**	0,69	0,5 – 2,2	19/24
	➢ **11 – 20 ng/ml**	1,04	0,4 – 2,1	18/15
	➢ **21 – 30 ng/ml**	0,87	0,6 – 4,8	12/12
	➢ **> 30 ng/ml**	1,62	0,6 – 4,8	13/7
	Alcool/THC	11,5*	4,6 – 36,7	66/6
Lowenstein & Koziol-McLain (2001), É.U.	Sans substances	1,0		114/126
	Alcool	3,2	1,1 – 9,4	17/6
	THC-COOH	1,1	0,5 – 2,4	17/17
	Alcool/THC-COOH	3,5*	1,2 – 11,4	16/5
				1209/372

Ratio de culpabilité relatif à la conduite sous l'influence du cannabis				
Auteurs	Substances	ratio	Intervalle de confiance à 95%	Conducteurs coupables/non coupables
Drummer et coll. (2001) & Swann (2000), Australie	Sans substances	1,0		720/39
	Alcool	5,7*	4,1 – 8,2	49/5
	THC	3,0*	1,2 – 7,6	24/0
	THC > 5 ng/ml	6,4*	1,3 – 115,7	68/26
	THC-COOH	0,8	0 – 1,3	65/62
	Alcool/THC	19*	2,6 – 136,1	

On constate selon les résultats de ces études que le cannabis seul n'augmente pas la probabilité de culpabilité lors d'accident. Toutefois, il faut noter que la plupart des études ont utilisé une mesure de THC-COOH, le métabolite inactif qui peut rester dans les urines plusieurs jours. Lorsque les auteurs ont distingué le THC seulement, on observe un ratio de risque légèrement plus élevé, même s'il n'atteint pas le seuil de signification. De plus, plus la concentration de THC augmente, plus le ratio augmente, suggérant encore une fois une relation dose-effet. Par ailleurs, la combinaison cannabis alcool augmente significativement le risque. Sans pouvoir conclure définitivement, on peut remarquer certains signes que leurs effets sont en synergie et non seulement additifs.

Les études qui portent sur des conducteurs blessés (Terhune (1982) et Hunter (1998)) les ratios sont un peu plus élevés que dans les autres études portant sur les tués. Selon Bates et Blakely (1999), la réduction apparente du risque d'accident mortel tiendrait au fait que les conducteurs sous l'influence du cannabis conduisent de manière moins risquée, réduisant leur vitesse notamment.[23]

En conclusion, nous sommes plutôt en accord avec l'INSERM sur ces études :

> *« Les résultats, en définitive, confirment l'importance du risque alcool, mais échouent généralement à démontrer un effet du cannabis seul sur le risque d'être responsable d'un accident mortel ou corporel grave. Les difficultés d'ordre méthodologique, qui rendent cette démonstration malaisée, contribuent pour une grande part à l'absence de résultats statistiquement indiscutables. Les analyses de responsabilité permettent néanmoins d'inférer que l'association entre l'alcool et le cannabis augmente le risque d'être responsable d'un accidente par rapport à la consommation d'alcool seule ; ce résultat demande toutefois à être consolidé. Enfin, les données les plus récentes tendent à monter que le risque d'être responsables augmente aux fortes concentrations de Δ^9THC. Cela concernerait notamment la consommation de cannabis précédant immédiatement la conduite et peut-être les consommateurs chroniques. »*[24]

[23] Cité dans INSERM (2001), *op. cit.*, page 192.

[24] INSERM (2001), *op. cit.*, page 194.

ÉTUDES EXPÉRIMENTALES

Les études épidémiologiques indiquent une présence relativement importante de conduite sous l'influence du cannabis, entre 5% à 12 % des conducteurs, davantage chez les jeunes hommes. En même temps ces études et les analyses de risque de culpabilité n'arrivent pas à des conclusions claires sur le rôle du cannabis dans la conduite dangereuse. De là découle l'intérêt des études sur les effets du cannabis sur les facultés reliées à la conduite et sur la conduite elle-même. Les études sur les qualités psychomotrices et cognitives requises pour la conduite de véhicules ont mesuré des dimensions telles : la coordination motrice, le temps de réaction, l'attention, la poursuite visuelle, et le raisonnement déductif. Les études sur la conduite sont de deux types : sur simulateur et en situation réelle de conduite, sur piste, en ville ou sur autoroute. La plupart des études portent sur la consommation de doses uniques chez des usagers récréatifs. Elles utilisent des devis avec groupe témoin et des devis croisés, notamment avec placebo et comparaison avec l'alcool. Toutefois, elles sont limitées par le fait qu'elles mesurent principalement les effets aigus de doses uniques, de sorte qu'il est difficile de déterminer si des usagers plus expérimentés réagiraient de la même manière. Les sections qui suivent examinent ces deux types d'études.

Activités hors conduite

Dès 1985, Moskowitz publiait une synthèse remarquable des études sur les effets psychomoteurs et cognitifs du cannabis.[25] Dans cette synthèse, il examine la coordination motrice, le temps de réaction, le tracking, et les fonctions sensorielles. L'auteur observe ce qui suit :

- La coordination motrice, mesurée par la stabilité des mains, le balancement du corps et la précision des mouvements, était significativement affectée. Toutefois, la pertinence de ces résultats pour la conduite automobile est limitée, sauf dans les situations de conduite qui exigent une grande coordination, comme les situations d'urgence. Il faut aussi ajouter les limites de ces études quant au dosage et au nombre de sujets testés (entre 8 et 16) ;
- Le temps de réaction n'est pas significativement modifié : « *Il existe suffisamment d'études expérimentales sur le temps de réaction dans des situations simples et complexes pour établir que ni la vitesse de la détection initiale ni la vitesse de la réponse ne sont, en soi, réduites par la marijuana. Il semble plutôt que, lorsque la marijuana entraîne une augmentation du temps de réaction, ce soit parce qu'une dimension quelconque de la tâche d'analyse de l'information soit en jeu.* »[26] L'attention, plutôt que le temps de réaction, serait modulée par la consommation de marijuana ;

---

[25] Moskowitz, H., (1985) « Marihuana and Driving. » *Accid. Anal. Prev.*, 17 (4), 323-345.
[26] *Ibid.*, page 330.

- La ligne droite : cette dimension est particulièrement sensible aux effets de la marijuana, la vaste majorité des études démontrant des réductions significatives à la capacité de garder une ligne droite ou de corriger les déviations par rapport à la ligne ;
- Les fonctions sensorielles (auditives et visuelles) sont souvent modifiées, mais les études ne produisent pas de résultats précis sur la distinction entre les tâches simples et les tâches complexes.

Ramaekers et coll., (2002), rapportent une méta-analyse portant sur 87 études contrôlées en laboratoire sur les effets psychomoteurs du cannabis menée par Berghaus et coll. (1998). Ces auteurs ont trouvé que le nombre de fonctions psychomotrices reliées à la conduite (poursuite, temps de réaction, perception, coordination œil-main, équilibre corporel, détection de signaux et attention divisée et continue) affectées par le THC atteignait son maximum au cours de la première heure après consommation fumée, et 1 à 2 heures après consommation orale. Les maxima étaient comparables à ceux obtenus avec une concentration d'alcool équivalant à > 0,05 g/dl. Le nombre de fonctions affectées atteignait zéro après 3 à 4 heures, seules les doses plus élevées continuant d'avoir des effets. Les études recensées démontrent aussi que la concentration de THC dans le sang est fortement corrélée aux effets psychomoteurs : une concentration entre 14 ng/ml et 60 ng/ml affectait entre 70 % et 80 % des tâches.[27]

Le tableau suivant résume ces données :

Détérioration des performances aux tests psychomoteurs selon la dose, le temps et le mode d'ingestion

Dose de THC	**Temps (en heures)**									
	< 1		**1-2**		**2-3**		**3 – 4**		**4 - 5**	
	Tests (n)	% affectés	Tests (n)	% affectés	Tests (n)	% affectés	Tests (n)	% affectés	Tests (n)	% affectés
Fumé										
< 9mg	271	61 %	33	36 %	10	30 %	10	0 %	11	0 %
9 – 18 mg	193	53 %	48	38 %	8	38 %	6	0 %	2	0 %
≥ 18 mg	64	64 %	28	36 %	10	40 %	15	53 %	3	67 %
Total	528	58 %	109	37 %	28	36 %	31	26 %	16	13 %
Oral										
< 9mg	3	33 %	49	14 %	37	8 %	13	8 %	-	-
9 – 18 mg	3	0 %	41	39 %	45	18 %	17	18 %	-	-
≥ 18 mg	3	0 %	45	60 %	15	33 %	15	33 %	11	45 %
Total	9	11 %	135	37 %	97	20 %	45	20 %	11	45 %

[27] Ramaekers J.G. et coll., (2002) *op. cit.*, page 77.

Plus récemment, après recension des études menées au cours des dernières années, les rapports de l'INSERM et de la Conférence scientifique internationale sur le cannabis arrivent à des conclusions largement similaires : le cannabis affecte le temps de réaction avec choix, le contrôle de la trajectoire, l'attention partagée et l'attention continue, ainsi que les processus de mémoire, mais n'affecte pas significativement le temps de réaction simple, ni les fonctions visuelles et oculomotrices.

En activité de conduite

L'une des faiblesses des études en laboratoire tient à la difficulté de relier les tâches psychomotrices et cognitives directement aux activités de conduite. Plusieurs tests mesurés dans ces études sont courts et relativement simples et ne reflètent pas nécessairement les situations réelles. L'avantage des études sur simulateurs de conduite et en situation de conduite sont plus susceptibles de ressembler à la réalité.

La plupart des études contemporaines ont des caractéristiques semblables : les sujets ont leur permis de conduire depuis au moins trois ans. Ils sont souvent des usagers réguliers de cannabis. Les sujets reçoivent du cannabis ou un placebo dans une situation « double aveugle » selon un minutage très strict de façon à contrôler le niveau de THC transmis. Dans certains cas, les expérimentateurs incluent aussi des comparaisons avec l'alcool et un placebo d'alcool. Notons cependant qu'il est impossible de contrôler le niveau que les sujets inhalent et absorbent réellement. Le cannabis préparé par le *National Institute of Drug Abuse* (NIDA) aux États-Unis varie entre 1,75 % THC pour les doses faibles, 2,67 % pour les doses moyennes et 3,95 % pour les doses fortes. Converti en µg/kg de poids, les doses correspondent à 100, 200 et 300 µg/kg, la dose forte recherchée par les usagers réguliers correspondant généralement à 308 µg/kg. Les sujets sont familiarisés avec l'équipement utilisé, les tâches à effectuer, et sont accompagnés par des moniteurs lors des études sur route. Les mesures portent sur le contrôle de la position latérale par rapport à la voie, le contrôle de la position longitudinale (distance) par rapport au véhicule qui précède, la prise de décision en situation d'urgence, le style de conduite et la prise de risques.

Le tableau qui suit, adapté de l'INSERM, résume certaines des études les plus récentes.

Effets du cannabis sur la conduite automobile[28]				
Milieu / Référence	**Sujet / Dose / Protocole**	**Tâches**	**Mesures**	**Résultats**
Simulateur				
Liguori et coll., 1998	10 usagers Placebo Cigarette 1,77 % THC fumée en 5 mn Cigarette 3,95 % THC fumée en 5 mn Test : 2 mn après Durée : 1 heure	Éviter en freinant une barrière apparue soudainement (55 à 60mph)	Temps total de freinage	? faiblement significatif à 1,77 THC, légèrement plus à 3,95
			Temps de latence pour lâcher l'accélérateur et appuyer sur le frein	pas de différence
		Jugement : maintenir une vitesse de 30mph sur une voie balisée et choisir la voie la plus large à embranchement	Vitesse moyenne Nombre de cônes renversés Nombre de choix réussis	Pas d'effet
Sexton et coll., 2000	15 usagers Placebo Herbe, dose faible 1,77 % THC Dose forte : 2,67 % THC 1 cigarette résine : 1,70 % THC Échantillon de sang et salive 10 mn après début Test 30 mn Durée : 25 mn	Section d'autoroute avec véhicule déboitant devant	Temps de réaction moyen	? à faible dose (forte variabilité à forte dose : ns)
		Section d'autoroute avec véhicule freinant devant	Temps de réaction moyen	? à faible dose (ns)
		Section d'autoroute de 16,7 km	Vitesse maximum minimum et moyenne	? moyenne de 6mph à faible et forte dose
		Virages à gauche, à droite	Écarts-type de la déviation ligne parfaite	? variation à forte dose vs faible dose ou placebo
		Carrefour avec feux sur route à 2 fois 2 voies	Temps de réponse au passage à l'orange	? à forte dose
			Temps moyen d'attente d'un point à 10m de la ligne d'arrêt	? à forte dose (grande variabilité : ns)
Sur route				
Robbe, 1998 étude no1 Portion fermée d'autoroute (cannabis)	24 usagers Placebo 100, 200 et 300 Test : 40 minutes et 1h40 après	Vitesse constante à 90km/h et contrôle de trajectoire sur 22km	Écart-type de la déviation latérale	? instabilité aux 3 doses
			Moyenne de la déviation latérale	pas d'effet
			Moyenne et écart-type de la vitesse	pas d'effet

[28] Tableau adapté de l'INSERM (2001), *op. cit.*, pages : 183-184.

Effets du cannabis sur la conduite automobile[28]

Milieu / Référence	Sujet / Dose / Protocole	Tâches	Mesures	Résultats
Étude no2 Trafic normal sur autoroute (cannabis)	16 usagers mêmes doses qu'étude 1 Test : 45 mn après	Contrôle de trajectoire (id) 64km, 50 mn	Mêmes mesures	mêmes effets
		Suivi de véhicule à 50m à vitesse variable (entre 80 et 100km/h) sur 16 km, 15 mn	Temps moyen de réaction	? ns
			Moyenne et écart-type des distances	Distance allongée de 8, 6 et 2 m pour 100, 200 et 300 THC
Étude no 3 Conduite en ville (cannabis)	16 usagers Placebo 100 Test : 30 mn après	Parcours en ville de 17,5 km Trafic dense, moyen ou léger	Observations externes	Pas de modification significative Pas d'effet
			Observations internes : maîtrise, manœuvres, virages…	
Étude no3 Conduite en ville (alcool)	16 usagers Placebo Alcoolémie : 0,5 g/l	Idem	Observations externes	Pas de modification significative
			Observations internes : maîtrise, manœuvres, virages…	Alcool 0,34 g/l modifie maîtrise et manœuvres
Robbe, 1998 Conduite sur autoroute (cannabis et alcool)	18 usagers THC : 100, 200 Alcool : 0,4 g/l Traitements : Alcool 0 + THC 0 Alcool) + THC 100 Alcool 0 + THC 200 Alcool 0,4 + THC 0 Alcool 0,4 + THC 100 Alcool 04 + THC 200	Trajectoire : vitesse à 100km et position latérale constante	Écart-type de la déviation latérale	? variabilité de trajectoire ; faible alcool seul, THC 100 seul ; Modérée : THC 200 Forte : alcool 0,4 et THC aux deux doses
	Alcool puis cannabis 60 mn après Tests entre 21 h et 23h15	Suivi : suivre un véhicule à 50 m dont vitesse varie de ± 15km/h toutes les 5mn	Temps de réaction	? temps de réaction pour alcool 0,4 et THC 200
		Conduite avec trafic	Moyenne et écart-type des distances	? variabilité de l'interdistance dans tous les cas
Lamers et Ramaekers, 2000 Conduite en ville (cannabis et	16 usagers THC 100 Alcool 0,5 g/l 4 traitements :	Conduite en ville 15 km	Fréquence des mouvements appropriés des yeux	Pas d'effet avec alcool seul ou cannabis seul

Effets du cannabis sur la conduite automobile[28]				
Milieu / Référence	**Sujet / Dose / Protocole**	**Tâches**	**Mesures**	**Résultats**
alcool)	Alcool 0 + THC 0 Alcool 0,5 + THC 0 Alcool 0 + THC 100 Alcool 0,5 + THC 100 Tests : 15 mn après Durée : 45 mn	Contrôle de la recherche visuelle	Qualité de conduite	? performances si alcool + cannabis Pas d'effet

Il est intéressant de se souvenir qu'une des premières études sur route avait été menée pour la Commission Le Dain.[29] Dans cette étude sur une piste en circuit fermé, 16 sujets recevaient chacun les 4 traitements suivants : placebo, marijuana 21 et marijuana 88 µg/kg THC et une dose d'alcool équivalant à BAC 0,07. Les tests étaient menés immédiatement après consommation et 3 heures après. Les sujets devaient compléter 6 tours de piste (1,8 km) avec manœuvres au ralenti en marche avant et en marche arrière, maintenir une trajectoire et contourner des cônes. L'alcool et la dose élevée de marijuana diminuaient les performances des conducteurs lors des tests immédiatement après consommation. À dose de cannabis élevée, les conducteurs maintenaient une vitesse réduite. Au second test, les différences s'estompaient.

Lorsqu'on compare les résultats de cette étude à celles qui ont été menées plus récemment avec des méthodes beaucoup plus sophistiquées, on constate que les résultats sont remarquablement similaires.[30] Ainsi l'on observe ce qui suit :

- Contrôle latéral : c'est la variable la plus sensible aux effets du THC mais les effets sont variables, notamment selon la dose et le temps ; seules les doses fortes affectent significativement le contrôle latéral du véhicule. Comparativement, l'alcool affecte davantage le contrôle latéral du véhicule et la vitesse (variables reliées) ;
- Contrôle de la vitesse : dans presque tous les cas, la consommation de cannabis diminue significativement la vitesse ;
- Prise de risques : en plus d'une diminution de la vitesse, on constate généralement une augmentation de la distance entre les véhicules chez les consommateurs de marijuana, une moins grande tendance à dépasser ou à faire des manœuvres dangereuses ;

[29] Voir Hansteen, R.W, et coll., (1976) «Effects of cannabis and alcohol on automobile driving and psychomotor tracking.» *Annals of the New York Academy of Science*, 282, pages : 240-256.

[30] Voir notamment la recension des études et la discussion dans Smiley, A., (1999) «Marijuana : On-Road and Driving Simulator Studies» in Kalant, H. et coll., (ed) *The Health Effects of Cannabis*. Toronto : Addiction Research Foundation, pages : 173 passim.

- Temps de décision : cette variable est particulièrement importante dans une situation de conduite réelle. En apparence, les résultats ne sont pas très cohérents. Par contre, Smiley suggère que le temps de réaction n'est pas affecté lorsque les sujets ont une indication qu'ils doivent répondre rapidement; par contre, lorsque les obstacles sont tout à fait imprévus, les sujets ayant consommé du cannabis sont moins performants ;
- Effets conjugués de l'alcool et du cannabis : lorsque les chercheurs ont vérifié les effets des deux substances, les effets conjugués du cannabis et de l'alcool étaient systématiquement plus importants que ceux de l'alcool seul et plus encore de ceux du cannabis seul.

Enfin, à faible dose les sujets ont l'impression que leur conduite est moins bonne qu'elle ne l'est selon les observateurs, ce qui n'est pas nécessairement le cas à doses plus élevées où les perceptions des uns et des autres sont en accord.

CONCLUSIONS

Le Comité est d'avis qu'il est vraisemblable que le cannabis rend les consommateurs plus prudents, notamment parce que, conscients de leurs déficiences, ils compensent par une réduction de la vitesse et par une moins grande prise de risques. Toutefois, en matière de conduite sous l'influence de cannabis, parce qu'il ne s'agit plus des conséquences sur les usagers eux-mêmes, mais des conséquences possibles de leur comportement sur d'autres personnes, le Comité est d'avis qu'il **convient d'opter pour la plus grande prudence**. Tenant compte de ce que nous avons vu dans ce chapitre, et malgré les limites méthodologiques dont souffrent les études menées sur le dépistage de la prévalence de conduite sous l'influence du cannabis, nous concluons comme suit :

	Conclusions du chapitre 8
Données épidémiologiques	➢ **Entre 5% et 12% des conducteurs pourraient conduire sous l'influence du cannabis ; ce pourcentage monte à plus de 20 % lorsqu'on isole les jeunes hommes de moins de 25 ans.** ➢ **Ce fait en soi ne signifie pas que les conducteurs sous l'influence de cannabis représentent un danger pour la sécurité routière.** ➢ **Une proportion non négligeable démontre la présence de cannabis et d'alcool simultanément.**
Données sur les effets sur la conduite	➢ **Le cannabis seul, surtout à faible dose, a peu d'effets sur les facultés reliées à la conduite automobile.** ➢ **Le cannabis, surtout aux doses correspondant aux doses élevées recherchées par les usagers réguliers, affecte**

	négativement le temps de décision et la trajectoire. ➢ Le cannabis mène à un style de conduite plus prudent. ➢ Les effets du cannabis conjugué à l'alcool sont plus importants que ceux de l'alcool seul.
Dépistage	➢ Malgré les progrès accomplis, il n'existe pour le moment aucun test rapide de dépistage en situation de conduite (roadside testing). ➢ Le sang demeure le milieu le plus sûr pour détecter la présence des cannabinoïdes. ➢ Les urines ne peuvent indiquer une consommation récente. ➢ La salive est un milieu prometteur mais les tests rapides commerciaux ne sont pas encore fiables. ➢ La méthode de reconnaissance visuelle par les policiers a démontré des résultats satisfaisants.
Mener des études	Il est essentiel de mener des études pour : ➢ Développer un outil de dépistage rapide. ➢ Mieux connaître les habitudes de conduite des consommateurs de cannabis.

CHAPITRE 9

APPLICATIONS THÉRAPEUTIQUES DU CANNABIS

La question des applications thérapeutiques du cannabis a connu, au cours des dernières années, un renouveau d'intérêt, au Canada notamment. En effet, suite à une décision de la Cour d'appel de l'Ontario invalidant les dispositions de la Loi sur les drogues relativement à l'usage médical du cannabis, le ministre fédéral de la Santé a adopté, en juillet 2001, une nouvelle réglementation permettant, sous certaines conditions, l'accès au cannabis à des personnes présentant des symptomatologies spécifiques. Plus tard cette même année, s'est tenue à La Haye aux Pays-Bas une conférence internationale sur le cannabis médical à laquelle participaient des délégations de plusieurs pays occidentaux, dont le Canada.[1] Plus tôt, en 1999, l'Académie américaine de médecine avait publié une synthèse des connaissances sur les applications thérapeutiques du cannabis.[2]

Pourtant, la communauté scientifique, médicale en particulier, est divisée quant à l'efficacité réelle du cannabis aux fins thérapeutiques. Certains n'hésitent pas à dire que la porte ouverte au cannabis médical serait en fait un pas vers la légalisation pure et simple du cannabis. En témoignent les deux citations suivantes, dont la première d'un ancien directeur du *National Institute on Drug Abuse* (NIDA) des USA :

> [Traduction] *« C'est le poids politique des défenseurs de la légalisation du cannabis qui crée la motivation à mener des études sur la marijuana fumée. (…) Leur clameur insistante à l'effet que seule la marijuana fumée est acceptable comme "médicament", leur insistance à faire fumer des malades en public, s'expliquent par le fait qu'ils savent que cet acte légitimise l'usage de la marijuana en changeant la perception publique de la marijuana d'une drogue nocive à un médicament utile. »*[3]

> [Traduction] *« Bien que plusieurs défenseurs de la marijuana médicale le fassent sur une base humanitaire et avec la ferme conviction que les bénéfices de la marijuana fumée ne sont pas disponibles*

[1] *International Conference on Medicinal Cannabis.* 22-23 novembre 2001, La Haye, Pays-Bas.

[2] Joy, J.E., Watson, S.J. & J.A. Benson (eds.) *Marijuana and Medicine : Assessing the Science Base.* Washington, DC., National Academy Press.

[3] DuPont, R.L. (1999) «Examining the Debate on the Use of Medical Marijuana. » *Proceedings of the Association of American Physicians.*, volume 111, no 2, page 169.

autrement, un appui important provient des défenseurs d'une libéralisation des politiques sur les drogues et de la décriminalisation de l'usage. »[4]

Il est vrai que, comme nous l'a rappelé le professeur Mark Ware lors de son témoignage devant le comité, dans le contexte juridique et politique actuel, la capacité est limitée de mener des études et surtout de le faire sans être influencé par le climat passionné des débats sur le cannabis.

> [Traduction] « *Regardons les effets que nos politiques actuelles sur les drogues ont eus sur notre compréhension du cannabis. Toutes les données sur les effets du cannabis sur la santé ont été recueillies sous un paradigme prohibitionniste. Cela peut sembler évident, mais il s'agit d'une source importante de biais. Pour connaître les effets du cannabis sur la santé, une estimation de l'usage dans la population en santé est importante. (…) Or, les taux de réponse aux enquêtes sur l'usage de drogues illicites sont notoirement faibles. Cela réduit notre capacité à tirer des conclusions sur les effets du cannabis quand on ne sait pas qui en consomme. Il est essentiel d'estimer le niveau de biais et ses effets, et toute bonne recherche tentera toujours de réduire les biais. Toutefois, mon expérience d'analyse critique de la littérature sur les effets du cannabis sur la santé, m'a amené à constater que plusieurs études estiment les risques sans avoir intégré des mécanismes de contrôle appropriés sur les biais de sélection. (…) La question n'est donc plus de savoir "comment les politiques sur le cannabis ont affecté la santé ?" mais de savoir "comment les politiques sur le cannabis ont affecté notre compréhension des effets du cannabis sur la santé ?"* »[5]

Il est vrai aussi que la question du cannabis médical nous interroge sur la conception même de la médecine moderne et ses liens avec l'industrie pharmacologique, puisque des recherches sur les cannabinoïdes ont déjà permis le développement de composés synthétiques de THC. Or, l'on sait que les industries pharmaceutiques ont joué un rôle important lors des négociations internationales menant à l'adoption des premières conventions internationales sur le contrôle des substances psychoactives.[6] De même, la plante de cannabis elle-même, parce que non brevetable, ne présente aucun intérêt pour les grands groupes de recherche pharmaceutique.

Au delà de la « preuve » scientifique de l'efficacité du cannabis et de la possibilité pour les médecins de le prescrire avec un degré suffisant de confiance, de nombreuses personnes sont convaincues, à partir de leur expérience personnelle, que le cannabis contribue directement à l'amélioration de leur mieux-être tout en entraînant un minimum de conséquences négatives. C'est d'ailleurs ce qui a mené à la création des « clubs compassion », ces organismes qui distribuent de la marijuana à une clientèle de

---

[4] Rosenthal, M.S. & H.D. Kleber (1999) «Making Sense of Medical Marijuana. » *Proceedings of the Association of American Physicians.*, volume 111, no 2, page 159.

[5] Dr Mark Ware, professeur adjoint de médecine familiale et d'anesthésie, Université McGill, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, 31 mai 2002.

[6] Voir là dessus notamment l'étude de W.B. McAllistair, *Drug Diplomacy in the 20th Century*. Il en sera question plus loin au chapitre 19.

plus en plus importante. L'une des questions qui nous est alors posée est celle de savoir quel degré de preuve faut-il atteindre avant de laisser des personnes utiliser librement le cannabis pour soulager une condition médicale. Ou même s'il faut réfléchir en termes strictement médicaux en cette matière.

Nous avons vu, au chapitre 7, que les effets à long terme du cannabis, même pour une consommation régulière, sont restreints et que même les effets les plus graves tels les cancers du poumon n'ont pas encore été établis clairement. Nous avons aussi vu que les effets négatifs sur les fonctions cognitives d'une consommation prolongée se manifestent plutôt chez des personnes déjà vulnérables, soit en fonction de leur jeune âge au début de la consommation soit en fonction de leur condition personnelle (par exemples, des prédispositions psychotiques). Nous avons aussi vu que, même présumant une certaine tolérance et un certain niveau de dépendance psychologique, celles-ci sont mineures, les signes de sevrage légers et les traitements moins souvent nécessaires et longs que pour d'autres drogues. Dans une certaine mesure, il semble bien que ce soient les propriétés psychoactives du cannabis qui, associées pour les uns à un refus de socialité, pour les autres à une personnalité faible, pour les autres encore à un comportement immoral, rendent cette substance suspecte, aussi bien dans ses applications médicales que non médicales.

En ce sens, la question du cannabis médical n'est pas tant une question de légalisation par la petite porte de côté, qu'une interrogation ouverte sur les conceptions sous-jacentes que chacun se fait de cette « drogue ». Un cas de figure en quelque sorte privilégié pour explorer nos préconceptions et nos biais. Affirmer, comme nous l'avons fait aux chapitres 6 et 7, que les conséquences psychologiques, physiologiques, ou sociales, de la consommation de cannabis semblent, selon toute vraisemblance, relativement bénignes, ne dit rien des bénéfices thérapeutiques de cette plante. Pas plus que les applications médicales du pavot n'indiquent les torts individuels ou sociaux que peut entraîner l'héroïne. C'est un peu ce que nous rappelait le Dr Kalant :

> *« La séparation des méthodes de contrôle suivant qu'il s'agit d'un usage médical ou non médical est généralement bien comprise. L'héroïne et la cocaïne ont des usages médicaux limités mais reconnus. (...) Pourtant, personne ne soutient qu'étant donné l'utilisation limitée de ces drogues à des fins médicales on devrait en légaliser l'usage non médical. (...) Le cannabis est peut-être la seule exception où l'utilisation possible à des fins médicales est souvent utilisée pour justifier la légalisation de son usage à des fins non médicales par certains de ceux qui préconisent la légalisation du cannabis. Cela me semble tout à fait irrationnel. Il n'y a aucune raison logique pour justifier que la légalisation de l'usage médical d'une substance serve d'argument pour obtenir la légalisation ou l'interdiction de l'utilisation de la même substance à des fins médicales. »*[7]

[7] Dr Harold Kalant, professeur émérite à l'Université de Toronto, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 11 juin 2001, fascicule 4, pages 70-71.

Pourtant, comme le soulignait à nouveau le Dr Ware, « *grâce aux cohortes massives de volontaires en santé qui ont consommé du cannabis au cours des quarante dernières années en Occident, la sécurité du cannabis a en fait été largement documentée. Le cannabis a en quelque sorte été l'objet de l'étude clinique de Phase I la plus extensive et la moins orthodoxe de toutes les drogues dans l'histoire.* »[8] Admettant que les protocoles de recherche pour admettre une substance à l'usage médical sont et doivent demeurer rigoureux, il n'y a pas de frontière étanche entre les deux domaines de recherche. C'est bien ce que démontrait en partie l'examen des études au chapitre 7 sur les effets et conséquences du cannabis. Surtout, l'approche inverse nous a semblé plus fréquente où, partant des effets néfastes présumés du cannabis sur la santé psychologique et physique, son utilité thérapeutique devient au moins suspecte. Nous en prendrons pour exemple la position de l'Association médicale canadienne.

Dans son témoignage devant le Comité, le Dr Haddad, président en exercice de l'Association a dit :

> *« Alors que nos connaissances sur tous les effets à long terme possibles des drogues sur la santé ne cessent d'évoluer, celles que nous possédons à ce sujet sont inquiétantes. Les risques pour la santé vont de certains effets aigus comme l'anxiété, la dysphorie ou la sensation d'être malade ou encore le déficit de la cognition, à des effets chroniques comme la bronchite, l'emphysème et le cancer. Les jeunes consommateurs canadiens ont eu en outre des problèmes pulmonaires comparables à ceux dus à la consommation de tabac quoique les effets soient beaucoup plus aigus et plus rapides. Les études indiquent que la consommation de deux ou trois cigarettes de cannabis par jour a les mêmes répercussions sur la santé que celle de 20 cigarettes ordinaires. Par conséquents, les effets potentiels à long terme de la consommation de cannabis pourraient être très graves.*
>
> *C'est notamment en raison de ces préoccupations au sujet des conséquences de la consommation de cannabis que l'AMC s'oppose au règlement fédéral actuel sur l'accès médical à la marijuana. Dans la lettre qu'elle a adressée au ministre de la Santé, l'AMC a signalé que l'on ne possédait pas de renseignements plausibles sur les risques et les avantages de la consommation de la marijuana à des fins médicales. Au cours des discussions que nous avons eues au sujet du règlement fédéral sur la consommation de marijuana à des fins médicales, nous avons mis l'accent sur les préoccupations que l'on a au sujet de ses effets sur la santé et sur des études qui indiquent que la marijuana est une substance qui provoque une accoutumance et qui a des effets psychoactifs connus et que, consommée sous forme de cigarette, elle est particulièrement nocive.*
>
> *Nous sommes arrivés à la conclusion que si les effets bénéfiques de l'usage médical de la marijuana ne sont pas encore connus, sa consommation comporte bel et bien des risques pour la santé. Par conséquent, il serait inapproprié que des médecins prescrivent de la marijuana à leurs patients ; c'est une prise de position qui a l'appui de l'Association médicale canadienne.*
>
> *(...)*
>
> *L'AMC craint que le présent débat concernant la décriminalisation et l'usage de la marijuana à des fins médicales ne légalise dans une certaine mesure sa consommation dans un simple but de détente. Il est important que le message que nous vous communiquons au sujet de la décriminalisation soit clair et bien*

[8] Dr Mark Ware, *loc. cit.*.

compris. Celle-ci doit être liée à une stratégie nationale de sensibilisation et de prévention fondée non seulement sur la recherche mais aussi sur un traitement global et sur un contrôle du programme.
(…)
L'AMC estime que tout changement concernant la politique en matière de drogues illicites devrait être progressif. Comme pour toute autre question liée à la santé publique, l'éducation et la sensibilisation aux effets potentiellement nocifs associés à la consommation de cannabis et d'autres drogues illicites sont essentielles dans le cadre de la lutte contre la toxicomanie. »[9]

Si l'on arrivait à démontrer que les effets ne sont pas aussi nocifs qu'on le pense, cela changerait-il quoi que ce soit aux questions relatives aux applications thérapeutiques du cannabis ? Pourtant, les effets aigus identifiés par l'AMC sont certes possibles mais plutôt rares, et souvent le fait soit de prédispositions personnelles, soit du contexte, soit encore d'un arrivage particulier de cannabis. En fait, les principales réactions aiguës, celles que la plus large partie de la recherche documente, sont plaisantes et contribuent effectivement à la détente. Si l'on arrivait à convaincre l'Association médicale que le cannabis crée peu d'assuétude et de dépendance, et que même lorsque c'est le cas elles sont relativement bénignes, cela faciliterait-il la prescription médicale de cannabis ? Or non seulement le cannabis n'est-il que faiblement associé à la « toxicomanie », mais la notion même de toxicomanie, a fortiori entendue comme maladie, est loin de faire consensus dans la communauté scientifique.

En fait, la question est ailleurs. Et à deux endroits. Premièrement, la connaissance des effets potentiellement nocifs du cannabis ne dit rien des qualités de la plante comme médicament. Certes, la connaissance des effets secondaires des médicaments, incluant leur potentiel addictif, est essentielle à la pharmacopée. Mais ces substances doivent d'abord être établies comme médicaments, notamment au titre de leur efficacité et de leur fiabilité. Deuxièmement, tout se passe comme si la résistance devant l'utilisation thérapeutique du cannabis ne reposait pas tant sur l'absence de connaissances médicales *stricto sensu* – ce qui est le cas par ailleurs dans une certaine mesure comme nous le verrons plus loin dans ce chapitre – que sur l'association faite entre le cannabis comme drogue et la toxicomanie. Vue sous cet angle, la question est en effet vite résolue : conformément à l'adage médical « *first do no harm* », un médecin ne prescrira pas un remède dont les effets risqueraient d'entraîner une maladie au moins aussi grave que celle qu'il vise à soigner. Inscrit au registre des drogues illicites, prohibé selon certains en raison de ses effets nocifs, et risquant d'entraîner la toxicomanie, quels arguments péremptoires permettraient alors de « sauver » le cannabis médical ?

Pourtant, rien de cela ne devrait avoir d'importance pour le médecin, pour le scientifique. Il ne s'agit pas de défendre un quelconque régime de politique publique global sur le cannabis, voire sur l'ensemble des drogues illicites. Il ne s'agit pas de traduire un message symbolique sur « les drogues ». Il ne s'agit pas d'avoir peur que les

---

[9] Dr Henry Haddad, président, Association médicale canadienne, témoignage devant le Comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 11 mars 2002, fascicule 14, pages 52-53 et 54-55.

jeunes puissent consommer du cannabis s'il était admis comme médicament. La question, la seule question qui se pose au médecin ici, est de savoir si, dans quelle mesure, et dans quelles circonstances, le cannabis a une utilité thérapeutique. De dire si des personnes atteintes de certaines maladies peuvent en bénéficier et de se prononcer sur les effets secondaires nocifs par rapport aux bénéfices. Et dans l'affirmative, de réfléchir ensuite aux modalités par lesquelles les patients pourraient se le procurer. Mais on voit bien que la question est fortement colorée par le contexte dans lequel elle se pose. Ce qui est bien sûr inévitable ; à condition de le dire clairement et sans détour.

Le reste de ce chapitre survole l'histoire des utilisations thérapeutiques du cannabis puis l'état des connaissances contemporaines sur le cannabis et les cannabinoïdes synthétiques. Nous décrivons ensuite brièvement le fonctionnement des clubs compassion et autres organismes qui fournissent du cannabis à des fins thérapeutiques, ainsi que divers régimes de politiques publiques. En conclusion, nous émettons notre avis sur les applications médicales du cannabis. Nous examinerons dans un chapitre ultérieur la question du régime de politique publique qui serait le plus approprié eu égard au statut du cannabis à des fins médicinales.

ASPECTS HISTORIQUES

Il semble bien que les utilisations thérapeutiques potentielles du cannabis aient été connues aussi loin que l'on puisse remonter dans l'histoire. En fait, il est probable que ces applications aient été connues avant même l'exploitation de ses propriétés psychoactives.

L'histoire médicale du cannabis est intimement liée à ses propriétés analgésiques, comme le souligne Ethan Russo :

> [Traduction] *« L'histoire du cannabis comme analgésique couvre au moins 4000 ans, incluant un siècle de médecine occidentale. (…) Les raisons tiennent des propriétés pharmacologiques remarquables de l'herbe, et les études scientifiques récentes démontrent les liens complexes que les cannabinoïdes possèdent avec notre biochimie interne. En fait, les cannabinoïdes forment un système parallèle au système opioïde endogène pour le contrôle de la douleur. De manière encore plus importante, le cannabis et ses contreparties synthétiques endogènes sont peut-être efficaces pour contrôler la douleur là où les opiacés et d'autres analgésiques échouent. »* [10]

Selon Russo, on a trouvé des documents écrits ou des traces ethnographiques de l'utilisation de cannabis à des fins médicales dans de nombreux pays. En Chine, un traité médical du IIe siècle rapporte qu'il était utilisé pour les anesthésies chirurgicales.

---

[10] Russo, E.B. (2002) « The role of cannabis and cannabinoids in pain management. » in Weiner, R.S. (ed.) *Pain Management. A Practical Guide for Clinicians.* Boca Raton, London, New York, Washington : CRC Press.

En Inde, le cannabis fait partie des traitements pour les migraines et douleurs viscérales depuis environ 2000 à 1400 avant l'ère chrétienne. En Égypte, où la plupart des érudits pensaient que le cannabis ne s'était pas implanté, on aurait trouvé des preuves de son utilisation dans la médecine depuis les temps pharaoniques. On en a ainsi retrouvé des traces dans les tombes des pharaons Amenophis IV et Ramses II. Il aurait été utilisé notamment pour les glaucomes et pour les douleurs de l'accouchement. Le cannabis était administré par voie orale, rectale, vaginale, appliqué sur la peau ou dans les yeux, et fumé.

En Assyrie, Sumer et Arcadie, il aurait été utilisé tant pour ses effets analgésiques, pour les migraines et les douleurs menstruelles, que pour ses propriétés psychoactives. On en a aussi trouvé des traces en Palestine et en Israël, notamment pour les douleurs reliées à l'accouchement. Les Grecs et les Romains s'en servaient pour le contrôle de la douleur en général, spécifiquement pour la goutte et les rhumatismes. Dans le monde musulman, on mentionne des applications thérapeutiques depuis le IXe siècle.

C'est vers le milieu du XVIIe siècle que la médecine occidentale aurait découvert les propriétés médicinales du cannabis. Un traité des plantes publié en 1640 au Royaume-Uni fait mention des usages du cannabis sous forme d'une pâte mélangeant le jus de la décoction avec d'autres ingrédients. En France, le traité du chanvre publié par Mercandier décrit diverses utilisations : séché et appliqué sous forme de cataplasme il diminuera les douleurs reliées aux tumeurs, bouilli et sous forme de cataplasme il aide à réduire les douleurs reliées aux rhumatismes, à la goutte et aux inflammations musculaires diverses, réduit en poudre et mélangé à du beurre, il diminue les douleurs reliées aux brûlures. Dans sa classification des plantes, Linnée reconnaît les propriétés médicales du cannabis pour réduire les douleurs.

L'utilisation médicale du cannabis s'est répandue au Royaume-Uni au milieu du XIXe siècle quand la plante a été rapportée de l'Inde. Il n'est pas jusqu'au médecin personnel de la Reine Victoria, Russell Reynolds, qui ne l'ait utilisé : dans ce cas, il s'est servi d'extrait de cannabis pour traiter la dysménorrhée de son illustre patiente au cours de toute sa vie adulte. Il soulignait notamment, dans un traité écrit en 1868, que, contrairement aux opiacées, l'utilisation du cannabis aujourd'hui n'entraînait pas la misère de demain.[11]

Des médecins et pharmaciens anglais, irlandais, français, puis américains, ont témoigné de diverses manières, entre 1890 et 1940, de l'utilité du cannabis sous diverses préparations, pour soulager la douleur. Un pharmacologue britannique a même, en 1899, réintroduit le fumage du cannabis, soulignant que le fait de le fumer est particulièrement utile si un effet immédiat est désiré.[12]

Le cannabis fait toujours partie de la pharmacopée, au moins informelle, de plusieurs pays du sud-est asiatique. Ainsi, cette description récente de son utilisation en Inde :

---

[11] Cité dans Russo, *op. cit.*, page 359.

[12] *Ibid.*, page 360.

[Traduction] *« Le charas est la sécrétion résineuse sur les feuilles et les fleurs des plants (équivalent au haschich arabe) ; c'est le principe actif du chanvre. C'est un narcotique utile, particulièrement lorsque l'opium n'est pas conseillé. Il est très utile pour soigner les maux de tête dus à la malaria et aux menstruations, les migraines, les manies aiguës, la toux phtisique, l'asthme, l'anémie cérébrale, les vomissements nerveux, le tétanos, les convulsions, les désordres mentaux, le délire, la dysporée, et la fatigue nerveuse. Il est aussi utilisé comme anesthésique, dans les cas de dysménorrhée, pour stimuler l'appétit et comme aphrodisiaque, pour soulager l'eczéma, et divers autres types de douleurs, etc. »* [13]

Il est aussi utilisé en Colombie, en Jamaïque et au Brésil notamment.

Il est évidemment tentant, tout épris de notre science moderne, de rejeter ces usages traditionnels dans les tiroirs des bonnes histoires de «médecines de bonne femme » - on excusera le terme – et autres recettes de charlatan. Pourtant, que le cannabis ait été utilisé depuis aussi longtemps pour les mêmes types de conditions, qu'il ait été parfois décrit avec autant de précision, qu'il ait franchi les cultures et les histoires, et que la médecine moderne fournisse des indications à l'effet que le cannabis pourrait effectivement être un adjuvant utile pour le traitement de la douleur chronique associée à diverses conditions médicales, devrait nous inviter à ne pas nous montrer trop cyniques devant ces usages « anciens ».

CONNAISSANCES CONTEMPORAINES

Deux questions nous semblent pertinentes ici. La première est de savoir si le cannabis a effectivement les effets thérapeutiques qui lui ont été prêtées traditionnellement ainsi que de plus récente date dans les histoires individuelles de personnes souffrant de douleurs chroniques et autres conditions. Dans l'affirmative, la seconde question, entièrement différente et répondant à des critères différents, est de savoir si le cannabis doit être considéré comme un médicament.

Utilisations thérapeutiques

La connaissance des mécanismes d'action des cannabinoïdes et du système cannabinoïde endogène permet d'abord de faire un certain nombre de constats. En termes généraux, et rappelant ce qui a déjà été dit au chapitre 5, on peut décrire l'action des cannabinoïdes de la manière suivante :

« (...) l'effet général est celui d'une inhibition de l'activité cellulaire, plutôt que de stimulation. Cela freine l'excitation du nerf, grâce à certaines réactions et notamment grâce à certains changements de milieu

[13] *Ibid.*, page 361.

et du mouvement des ions, ce qui modifie la réaction de la cellule à l'excitation, et notamment la façon dont elle communique avec les autres cellules de la chaîne.
Cette action inhibitrice se fait par le truchement d'une ouverture des canaux de potassium, entraînant une excitation décroissante de la cellule, et une fermeture des canaux de calcium, entraînant une inhibition générale de l'activité cellulaire. Voilà donc des mécanismes qui peuvent avoir des conséquences thérapeutiques importantes, dans certaines situations cliniques, de douleurs ou de spasmes, puisqu'on diminue l'activité nerveuse dans les réseaux de transmission de la douleur. » [14]

De manière plus spécifique, les cannabinoïdes agissent sur divers systèmes neurophysiologiques associés à la douleur, soit seuls, soit en association avec le système des opiacées endogènes.[15] Les cannabinoïdes agissent sur la libération de sérotonine qui est elle-même associée à diverses formes de douleur, notamment les migraines. L'anandamide, et d'autres antagonistes cannabinoïdes bloquent la libération de sérotonine et de la ketanserine, toutes deux associées aux migraines, laissant présumer de l'effet potentiel du THC. Les cannabinoïdes sont aussi reliés au système dopaminergique, dont il a été démontré qu'il est relié aux migraines et à d'autres formes de douleur. De même, les cannabinoïdes inhibent l'action de la prostaglandine, permettant ainsi une action anti-inflammatoire. Certaines études ont démontré que le THC était en ce sens un analgésique plus puissant que l'aspirine ou même que la cortisone. Interagissant avec les systèmes opioïdes endogènes, les cannabinoïdes augmentent la libération de beta-endorphines qui réduisent les effets des migraines. Selon certaines études, les applications thérapeutiques du THC seraient potentiellement plus importantes que celles de la morphine, soit parce que plus spécifiques dans certains cas, soit parce que dans d'autres cas la morphine aggrave certaines symptomatologies, soit encore parce que le THC n'a pas les propriétés sédatives de la morphine. De même, le THC aurait un effet antinociceptif sur la matière grise de l'aire périacqueductale. Enfin, le THC agit comme bloquant de la libération des glutamates, permettant ainsi de réduire les douleurs musculaires et inflammatoires.

[Traduction] *« Les chercheurs italiens Nicolodi, Sicuteri et leurs collègues ont récemment élucidé le rôle des antagonistes du NMDA pour éliminer l'hyperalgésie des migraines, des maux de tête quotidiens chroniques, de la fibromyalgie, et d'autres mécanismes de la douleur. Ils ont suggéré que les acides gaba et la ketamine pouvaient agir comme agents bloqueurs du système de la douleur et améliorer la condition du patient. À partir de ces observations et relations, il est logique que l'usage prolongé du THC comme prophylactique puisse produire des bénéfices similaires, comme le démontrait déjà la pratique thérapeutique des maux de tête chroniques au XIXe siècle par l'usage d'un extrait de chanvre indien. »*[16]

---

[14] Dr Mary Lynch, Directrice, consortium canadien de recherche sur les cannabinoïdes, professeure, Université Dalhousie, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 11 juin 2001, fascicule 4, page 49.

[15] Les informations qui suivent sont tirées notamment de Russo, *op. cit.*, Hartel, C.R., « Therapeutic Uses of Cannabis and Cannabinoids. » in Kalant, H. (ed.) *The Health Effects of Cannabis*. Toronto : Addiction Research Foundation, et de INSERM (2001), *op.cit.*

[16] Russo, *op. cit.*, page 365.

Concrètement, ces mécanismes d'action signifient que les cannabinoïdes peuvent avoir des effets bénéfiques dans une série de situations impliquant notamment mais pas exclusivement la douleur. Les principales sont les suivantes.

- Antiémétique : dans les cas de traitement par chimiothérapie de personnes atteintes de cancer, les nausées ressenties suite au traitement sont une condition fréquente. C'est d'ailleurs suite à une série de cas cliniques sur des personnes rapportant avoir soulagé leurs vomissements par suite de consommation de cannabis que les composés synthétiques dranobinol (ou Marinol) ainsi que nabilone (ou Cesamet) ont été développés et testés principalement aux États-Unis et en Grande-Bretagne depuis les années 1970. Selon le Dr Lynch, « *les cannabinoïdes sont considérés comme un antiémétique doux. Il y a d'autres antiémétiques disponibles plus efficaces. Cependant, comme les antiémétiques fonctionnent à partir d'un certain nombre de mécanismes assez divers, et parce que nous avons besoin de viser plusieurs mécanismes à la fois pour traiter la nausée et les vomissements, les cannabinoïdes semblent être prometteurs, et nous offrir une nouvelle possibilité.* » [17]

- Cachexie : un nombre important de personnes atteintes de VIH Sida souffrent d'une anorexie progressive accompagnée de perte de poids. Certains travaux démontrent que les cannabinoïdes peuvent contribuer à améliorer cette situation, notamment parce que le THC augmente l'appétit. Certaines réserves ont été émises relativement aux effets nocifs du THC fumé sur le système immunitaire : [Traduction] « *Plus récemment, Nieman et coll., (1993) ont démontré que le fumage de tabac chez les personnes séropositives serait associé à un développement plus rapide du Sida parce que fumer augmente la prévalence de Pneumocystis carinii pneumonia (PCP).* »[18] D'autres par contre arrivent à des conclusions différentes : [Traduction] « *L'une des préoccupations de santé publique concerne les effets du cannabis sur le VIH/Sida. Au moins quatre études peuvent réduire ces inquiétudes. Kaslow et coll., (1989) n'ont trouvé aucune preuve que le cannabis accélérait les paramètres d'immunodéficience chez les personnes séropositives. DiFranco et coll., (1996) ont indiqué n'avoir observé aucune accélération du VIH au Sida chez les usagers de cannabis. Whitfield, Bechtel et Starich (1997) n'ont observé aucun effet nocif du cannabis chez les patients atteints de VIH / Sida, même chez ceux qui avaient le niveau de CD4 le plus faible. Enfin, Abrams et coll., (2000) ont mené une étude randomisée, partiellement aveugle avec contrôle placebo, chez des personnes séropositives, sur les inhibiteurs de protéase. Ils n'ont observé aucun effet négatif sur le compte de CD4 découlant de l'usage du cannabis.* » [19]

---

[17] Dr Mary Lynch, *op. cit.*, page 52.

[18] Hartel, R.D., *op. cit.*, page 465.

[19] Russo, E.B., et coll., (2002) « Chronic cannabis use in the compassionate investigational new drug program : An examination of benefits and adverse effects of legal clinical cannabis. » *Journal of Cannabis Therapeutics*, vol 2, no 1, page 45.

- Glaucome : le glaucome est une maladie oculaire qui se manifeste notamment par une pression intraoculaire de plus en plus grande à cause de difficultés de drainage du liquide qui coule dans l'œil, et entraîne la destruction progressive des nerfs oculaires. L'utilisation du cannabis, notamment de pâte à base de feuilles de cannabis, pour diminuer la pression intraoculaire est connue depuis les temps anciens comme nous l'avons vu à la section précédente. Des études récentes tendent à indiquer que le cannabis permet de réduire les effets du glaucome – incluant le cannabis fumé. Par contre, certaines réserves ont été émises en raison de certains effets secondaires du cannabis fumé (rougeur et sécheresse des yeux). Dans une étude de cas menée par Russo et coll., sur quatre patients utilisant du cannabis fumé, une patiente atteinte de glaucome affirmait en cour que le cannabis lui avait sauvé la vue.

- Antispasmodique et anticonvulsif: les propriétés anticonvulsives du cannabis pour contrôler les crises d'épilepsie et anstispasmodiques dans les cas de sclérose en plaques sont bien connues au Canada puisque, notamment dans le premier cas, elles ont été à l'origine de la décision de la Cour d'appel de l'Ontario dans l'arrêt Parker. Le cannabis fumé aussi bien que les cannabinoïdes synthétiques semblent efficaces pour contrôler ces manifestations. Toutefois, la biodisponibilité des composés synthétiques (entre 20 % à 30 %) et leur effet retardé par rapport au cannabis fumé, semblent à l'origine de la préférence de ces patients pour le fumage.

- Analgésique : les effets analgésiques du cannabis pour calmer une série de douleurs sont aussi connus depuis l'antiquité. Nous en avons décrit, plus haut, les mécanismes d'action. Plus important encore, le cannabis a des effets spécifiques sur certaines douleurs que les opiacées n'ont pas.

Le cannabis comme médicament ?

Pour qu'un produit soit reconnu comme médicament dans la pharmacopée, il doit répondre à au moins trois critères :

- Qualité : le dosage doit être établi selon une composition constante et connue facile à administrer au patient ;
- Efficacité : des essais cliniques rigoureux doivent avoir établi l'efficacité du médicament ; et
- Sécurité : les études doivent permettre d'établir les effets secondaires prévisibles et connus du médicament.

En raison de l'absence d'études cliniques rigoureuses, suivant les protocoles reconnus, le cannabis à l'état pur n'a pas encore rencontré ces critères. Une série de raisons peuvent expliquer cette situation. Premièrement, les protocoles de recherche requis pour tester les médicaments impliquent des tests en double aveugle avec groupe de contrôle et randomisation des sujets, toutes conditions qu'il est difficile de réaliser avec le cannabis. Deuxièmement, le climat juridique actuel limite la capacité de mener de telles études, tant en termes de la disponibilité du cannabis que des conditions expérimentales. Troisièmement, le cannabis rendu disponible par le *National Institue of Drug Abuse* (NIDA) pour les recherches médicales – incluant celles menées par Santé Canada – est de qualité douteuse[20] : alors que la concentration en THC peut être un élément déterminant pour la qualité des effets thérapeutiques, le cannabis fourni par le NIDA ne contient qu'entre 1,8 % et 5 % de THC. De plus, un cannabis plus faible requiert davantage de tires et libère plus de CO qu'un cannabis à plus haute teneur. Les autres cannabinoïdes présents ne sont pas mesurés alors qu'on sait qu'ils interviennent aussi dans les propriétés médicales du cannabis. Le papier dans lequel les cigarettes sont roulées serait de mauvaise qualité. Le cannabis est souvent âgé de plus de deux ans et n'a pas nécessairement été conservé dans des conditions lui permettant de conserver toutes ses qualités. Enfin, il contiendrait beaucoup de graines et autres détritus de la plante. Quatrièmement, il est difficile de contrôler la quantité de cannabis réellement absorbé par les sujets : la manière de tirer sur la cigarette, l'habitude de fumer ou non, les préférences de chaque sujet, le temps durant lequel le sujet inhale, sont autant de facteurs qui peuvent influencer les conditions expérimentales et que les chercheurs n'arrivent pas à mesurer avec précision.

Il faut aussi pouvoir répondre à certaines questions, notamment :

- Y a-t-il une différence entre les cannabinoïdes synthétiques et le cannabis à l'état pur ?
- Quel profil de cannabis est optimal dans quelles circonstances ?
- Les diverses formes de dosage et d'ingestion entraînent-elles des différences significatives ?

Au cours des dernières années, des synthèses de la littérature scientifique ont été proposées par l'Institut américain de médecine, la société britannique de médecine, et divers rapports gouvernementaux, notamment au Royaume-Uni et aux Pays-Bas. L'Institut américain de médecine a conclu notamment qu'il existe des indications sur le potentiel thérapeutique du cannabis comme analgésique, antiémétique et stimulation de l'appétit. Il a cependant souligné que le cannabis fumé est un moyen d'ingestion difficile à contrôler qui a aussi des effets secondaires, spécifiquement eu égard à son potentiel cancérogène et aux maladies respiratoires. L'Institut a aussi observé que les effets psychoactifs du cannabis sont parfois bénéfiques pour certains patients mais pas dans tous les cas. Enfin, l'Institut a souligné que le cannabis fumé ne devrait pas être

---

[20] Russo, *op. cit*, note 17, fait une discussion plus poussée de ces diverses faiblesses.

recommandé à long terme en raison de ses effets physiques potentiels mais qu'il pourrait être prescrit dans les cas de maladies terminales ou dégénératives où les préoccupations à long terme sont secondaires. Aux Pays-Bas, le Conseil national de la santé a émis un avis en 1995 soulignant que les preuves scientifiques sur l'usage médical de cannabis sont insuffisantes en raison de devis de recherche faibles et d'imprécisions quant aux propriétés du cannabis fumé. Il a aussi indiqué que le cannabis pourrait avoir des applications thérapeutiques dans les domaines suivants : nausées et vomissements reliés à la chimiothérapie, stimulation de l'appétit pour les sidéens et cancéreux, sclérose en plaque et glaucomes. En 2001, les Pays-bas ont créé un Bureau sur l'utilisation du cannabis médical au sein du ministère de la Santé et commencé des études cliniques. Au Royaume-Uni, la Chambre des Lords a adopté une position similaire à celle de l'Institut américain de médecine et le ministère de la Santé mène présentement au moins une étude clinique.

Il est clair que **les connaissances sur le cannabis sont insuffisantes pour l'établir comme médicament au sens strict et que les connaissances sur les cannabinoïdes sont encore partielles**. En ce qui concerne les cannabinoïdes, il s'agit le plus souvent d'un seul composé cannabinoïdique, alors que le cannabis contient plusieurs substances dont les effets interagissent pour entraîner les bénéfices thérapeutiques. Mais la recherche n'a pas encore permis de déterminer spécifiquement le rôle des divers cannabinoïdes. Les patients utilisant les composés synthétiques à base de dronabinol ou de nabilone rapportent le plus souvent ne pas ressentir les mêmes effets bénéfiques que lorsqu'ils fument l'herbe. Les effets seraient plus lents à se faire sentir et moins spécifiques. De plus, le fait d'isoler un seul des composants du cannabis serait, selon un certain nombre d'études, relié à une augmentation des risques de crises d'anxiété voire de psychose cannabinique.

> [Traduction] *« Le fait que la marijuana naturelle puisse être fumée constitue un avantage significatif puisque son action est plus rapide et que le patient peut ajuster la dose. (...) Les rapports provenant de patients et d'oncologues indiquent que la marijuana fumée est légèrement plus efficace et aussi sécuritaire que les cannabinoïdes oraux disponibles légalement. Au-delà des avantages reliés à la forme fumée de la marijuana, une autre différence importante entre la marijuana et le THC, tient au fait que le 9-THC isolé peut entraîner relativement souvent des crises d'anxiété et des attaques de panique. (...) Ces effets peuvent aussi se produire avec la marijuana, mais ils sont moins importants en raison de la présence de cannabidiol, un composé non psychoactif qui a des propriétés antipsychotiques. »* [21]

Enfin, il faut aussi compter avec les coûts des composés synthétiques, qui sont nettement plus élevés que ceux de l'herbe.

En ce qui concerne le cannabis fumé, ses avantages sont de permettre au patient d'établir lui-même la dose nécessaire et de ressentir les effets plus rapidement, tout en limitant les effets secondaires nocifs, sauf les effets sur les voies respiratoires. Notons

---

[21] Gurley, R.J., Aronow, R. & M. Katz (1998) «Medicinal marijuana : A comprehensive review.» *Journal of Psychoactive Drugs.* Vol 30, no 2, page 139.

d'ailleurs au passage l'importance de cet effet de modulation de l'usage par les patients : la plupart des cas cliniques rapportés ainsi que les témoignages des responsables des organismes de compassion, s'accordent pour affirmer que les patients préfèrent consommer du cannabis plus concentré en THC que ceux qui en font un usage récréatif, mais qu'ils ne prennent que la quantité nécessaire pour obtenir les effets calmants. Par contre, les difficultés reliées à la connaissance précise de son efficacité et de sa qualité font défaut, limitant ainsi la capacité du médecin à prescrire la dose appropriée. Les connaissances les plus avancées sur le cannabis fumé concernent son degré de sécurité, même si l'interprétation des données n'est pas unanime. Nous partageons généralement la conclusion du professeur Scholten :

> [Traduction] *« L'usage du cannabis à des fins médicales chez les patients ayant une condition somatique est relativement sécuritaire, à condition de ne pas être fumé. Lorsque fumé, le cannabis a le même potentiel cancérogène que le tabac. Les alternatives sont l'administration par voie orale ou l'inhalation par un vaporisateur.*
> *La toxicité aiguë du cannabis est très faible ; il est presque impossible de faire une surdose de cannabis (il faudrait manger ou fumer l'équivalent de son poids en cannabis frais, soit environ 7 500 grammes de cannabis séché). Les principaux effets secondaires du cannabis en thérapeutique sont la phychose et l'euphorie. On sait peu de choses du potentiel addictif du cannabis thérapeutique mais les connaissances acquises sur l'usage de la morphine comme analgésique démontrent que le risque de dépendance psychologique est beaucoup plus faible en situation médicale que lorsqu'elle est utilisée comme stimulant. Puisque le potentiel addictif du cannabis est faible lorsqu'il est utilisé comme stimulant, on peut penser qu'il en serait de même en situation clinique.*
> *En ce qui concerne la toxicité chronique du cannabis, il faut se rappeler que les doses utilisées aux fins thérapeutiques seront probablement moins élevées que pour les usages récréatifs, réduisant ainsi les risques d'effets secondaires. »*[22]

Cela signifie-t-il qu'il faut décourager voire interdire l'usage du cannabis, surtout du cannabis fumé, dans un contexte thérapeutique ? La dernière section se penche sur cette question.

PRATIQUES THÉRAPEUTIQUES ACTUELLES

Les principales réserves sur l'utilisation thérapeutique de l'herbe concernent d'une part l'absence de connaissances rigoureuses provenant d'études médicales contrôlées, et d'autre part ses effets secondaires à long terme sur les voies respiratoires et son potentiel cancérogène. Dans certains cas, des réserves sont aussi exprimées sur les propriétés psychoactives du cannabis. Par ailleurs, il se dégage un consensus de plus en

---

[22] Scholten, W.K. (2002) « Medicinal cannabis : A quick scan on the therapeutic use of cannabis. » in Pelc, I., (ed.) *International Scientific Conference on Cannabis.* Bruxelles.

plus large sur le potentiel thérapeutique du cannabis, notamment pour la plante fumée. Si le cannabis ne peut, à proprement parler, être considéré, pour le moment du moins, comme médicament, mais qu'il a néanmoins des propriétés thérapeutiques, comment alors le classifier et le gérer ?

Il s'est développé, dans plusieurs pays, notamment au Canada et aux États-Unis, une pratique parallèle de recours à l'herbe par des personnes souffrant de certaines conditions. L'exemple le plus connu au Canada est sûrement celui du Club Compassion de Vancouver.

Dans son énoncé de mission, l'organisme propose une approche holistique de la santé. Il fournit non seulement du cannabis mais aussi d'autres formes de médecines naturelles (herbothérapie, acupuncture, massages, etc.). Il s'appuie sur les valeurs de compassion, d'affranchissement, de complémentarité entre les approches.

Il s'est développé, au cours des six années d'existence du Club Compassion, une connaissance intime des effets thérapeutiques du cannabis. Le Club offre en permanence entre sept à dix variétés de cannabis, une ou deux de haschich, de la résine de cannabis et des pains et gâteaux au cannabis. Il vend l'herbe entre 3$ et 10 $ le gramme, selon la variété. Il offre des services à plus de 2 000 membres/clients maintenant.

> *« Nos membres présentent les symptômes et les états les plus divers : le VIH et le sida, le cancer, la sclérose en plaques, l'arthrite, la douleur chronique, le fibromyosite, l'épilepsie, le glaucome, l'hépatite C, l'anxiété, la dépression, l'insomnie, les troubles alimentaires et bien d'autres affections encore.*
> *(...)*
> *Il importe que les consommateurs de cannabis à des fins médicales aient accès à différentes variétés du produit car l'effet du cannabis dépend de la variété employée et de la méthode d'ingestion. Nous expliquons les différences pertinentes à nos membres, qui peuvent alors choisir la variété de cannabis qui convient le mieux pour traiter efficacement leurs symptômes.*
> *L'indica et le sativa sont les deux principales variétés de cannabis utilisé à des fins médicinales. Nombre de souches résultent du croisement de ces deux variétés. À l'intérieur de chacune de ces variétés et de ses croisements, il y a un nombre extraordinairement élevé de souches individuelles, dont chacune comporte des effets et des caractéristiques cannabinoïdes qui lui sont propres.*
> *Selon les données empiriques dont on dispose, les souches d'indica ont un effet calmant et sont efficaces pour contrer l'anxiété, la douleur, la nausée, pour stimuler l'appétit, pour susciter le sommeil, pour vaincre les spasmes musculaires et les tremblements entre autres symptômes. Les souches du sativa ont davantage un effet stimulant, efficace pour stimuler l'appétit, soulager la dépression, les migraines, les douleurs et les nausées. Nous sommes maintenant au courant de souches spécifiques qui sont efficaces pour traiter des symptômes et des états particuliers. Les membres notent leur consommation afin de repérer la souche la plus efficace dans leur cas. Nous effectuons également un suivi serré des membres afin de pouvoir les aider à connaitre leurs propres habitudes de consommation et, pour nous-mêmes, afin de pas revendre aux mêmes personnes et afin d'encourager une consommation responsable. »*[23]

[23] Mme Hilary Black, directrice du Club Compassion de Vancouver, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 7 novembre 2001, fascicule no 10, page 36.

À la lecture de ce témoignage et des documents qui nous ont été remis par le Club, suite à la visite que nous avons faite des locaux de l'organisme et de l'occasion qui nous a été offerte de voir ses dossiers, suite aussi aux témoignages d'autres personnes oeuvrant dans des organismes similaires à Montréal et à Toronto, nous ne pouvons que constater les rapprochements entre cette pratique thérapeutique et les données issues de la recherche sur les applications médicales du cannabis.

Nous observons aussi que cet organisme, comme les autres qui fournissent un service similaire au Canada, tiennent des registres détaillés de leurs clients et de leur consommation de cannabis, matériel qui permet un suivi thérapeutique mais qui pourrait aussi constituer un excellent matériau de recherche empirique. **Nous ne pouvons que regretter que Santé Canada n'ait pas engagé un processus de recherche clinique en collaboration avec cet organisme.** Nous partageons d'ailleurs les réserves exprimées par Mme Black quant aux protocoles traditionnels de recherche sur les applications thérapeutiques du cannabis :

> *« Nous avons dressé un plan de recherche de concert avec une équipe de scientifiques de Vancouver. Notre proposition a toutefois été rejetée parce que nous refusons de faciliter une étude qui comporte l'utilisation d'un placebo ou d'une variété de cannabis de faible qualité et de faible puissance importée de la National Institute on Drug Abuse des États-Unis. Toute étude visant à prouver l'efficacité du cannabis en tant que médicament, mais à l'aide d'une plante à faible puissance ou de souches inconnues comme celles que cultivent actuellement Prairie Plant Systems et Santé Canada est vouée à l'échec. Il n'est pas nécessaire d'importer du cannabis aux fins des recherches car nous produisons au Canada un cannabis de première qualité en quantité énorme. L'information que nous pourrions recueillir est demandée par des médecins, des patients, des compagnies pharmaceutiques, Plant Prairie Systems et Santé Canada ; néanmoins, nous n'avons pas les moyens financiers de faciliter les recherches en question. »*[24]

Personne ne niera qu'il faut continuer les recherches sur les applications thérapeutiques du cannabis, fumé ou de synthèse, afin de tenter de mieux connaître les éléments clés de qualité, d'efficacité et de sécurité. Chacun soutient qu'il y aurait intérêt à mieux connaître les souches et dosages appropriés à diverses conditions. Pour autant, faut-il penser faire du cannabis un médicament au même titre que les médicaments inscrits dans la Pharmacopée ? Faut-il avoir les mêmes exigences que celles qui concernent les médicaments prescrits ou plutôt assouplir les règles pour en faire une médecine naturelle alternative ? S'il n'en était du régime juridique et des Conventions internationales qui régissent le cannabis, cette plante ne serait-elle pas plutôt considérée comme une médecine naturelle au même titre que d'autres plantes et herbes ?

Penser en ces termes nous force à réfléchir autrement à la question des applications thérapeutiques du cannabis. Si l'on cherche à en faire un médicament, les réserves du corps médical, du moins d'un certain nombre de ses représentants, peuvent se comprendre : tant que n'ont pas été menées les études contrôlées requises qui

---

[24] *Ibid.*, page 39.

permettront aux médecins de le prescrire avec la même confiance qu'ils le feront d'un médicament dûment inscrit, ils ne pourront que se dissocier de cette approche. Si l'on reconnaît que le cannabis a des applications thérapeutiques dans un certain nombre de cas – au moins aussi éprouvées que pour n'importe quelle autre plante utilisée en homéopathie ou en herbothérapie – alors il s'agit plutôt de lui donner un statut équivalent aux médecines naturelles.

CONCLUSIONS

Le Comité est d'avis que les applications thérapeutiques potentielles du cannabis ont été **suffisamment bien documentées pour que son utilisation à des fins thérapeutiques soit permise**. Il convient de reconnaître que sous sa forme fumée, le cannabis peut présenter certains effets secondaires nocifs, notamment sur les voies respiratoires et d'en aviser les usagers conformément. Il convient aussi de reconnaître que des études sont nécesssaires pour préciser davantage le champ spécifique d'application du cannabis et ses effets sur le long terme.

Conclusions du chapitre 9	
Applications thérapeutiques	➢ **Il existe des indications claires, quoique non définitives sur les bénéfices thérapeutiques du cannabis dans les conditions suivantes : analgésique pour les douleurs chroniques, antispasmodique pour la sclérose en plaques, anticonvulsif pour l'épilepsie, antiémétique pour la chimiothérapie et stimulation de l'appétit pour la cachexie.** ➢ **Il existe des indications moins claires quant aux effets du cannabis sur le glaucome et d'autres conditions médicales.**
Le cannabis comme médicament	➢ **Le cannabis n'a pas été établi comme médicament par des études contrôlées et rigoureuses.** ➢ **La qualité et l'efficacité du cannabis, principalement fumé, n'ont pas été déterminées dans des études cliniques rigoureuses.**
Cannabis et composés synthétiques	➢ **Les composés synthétiques ont fait l'objet d'un certain nombre d'études mais les connaissances sont encore insuffisantes pour en établir l'efficacité et la sécurité.** ➢ **Règle générale, les effets du cannabis fumé sont plus spécifiques et plus rapides que ceux des composés synthétiques.**

	➢ L'absence de certains cannabinoïdes dans les composés synthétiques peut entraîner des effets secondaires nocifs tels les crises de panique ou les psychoses cannabiques. ➢ Le cannabis fumé présente des effets nocifs potentiels surtout sur les voies respiratoires. ➢ Les personnes qui fument du cannabis à des fins thérapeutiques modulent leur consommation en fonction de leur condition physique et n'en recherchent pas tant les effets psychoactifs. ➢ Les personnes qui fument du cannabis à des fins thérapeutiques préfèrent avoir le choix de la forme d'utilisation.
Pratiques thérapeutiques	➢ Il convient de soutenir et d'encourager le développement des pratiques alternatives telles que mises en œuvre dans les clubs compassion. ➢ Les pratiques de ces organismes sont en accord avec les indications thérapeutiques provenant des études cliniques et respectent des règles strictes de qualité et de sécurité.
Recherche	➢ Les études déjà approuvées par Santé Canada doivent être menées dans les meilleurs délais. ➢ Les qualités du cannabis utilisé dans ces études doivent correspondre aux standards de la pratique actuelle dans les organismes de compassion et non aux standards de NIDA. ➢ Les études devraient notamment porter sur les applications et le dosage spécifiques pour différentes conditions médicales. ➢ Santé Canada devrait, dans les meilleurs délais, engager une étude clinique en collaboration avec les organismes de compassion au pays.

CHAPITRE 10

OPINIONS ET ATTITUDES DES CANADIENS

L'un des objectifs importants que nous avons poursuivi tout au long de nos travaux était d'impliquer les Canadiens. Nous voulions par là entendre leurs opinions, leurs expériences, leurs appréhensions face au cannabis. Et nous voulions aussi rendre accessible l'information dont nous disposions de sorte à contribuer, à la hauteur de nos modestes moyens, à une meilleure connaissance des réalités du cannabis, seule à même de hausser le niveau des débats publics. Au début de chacune des audiences publiques, le président du Comité le présentait d'ailleurs en ces termes :

> *« Le second de ces enjeux est celui du partage de la connaissance. Il s'agit assurément du plus noble. Le Comité désire que les Canadiens de partout s'informent et partagent l'information que nous avons recueillie. Notre défi sera de planifier et d'organiser un système assurant l'accessibilité et la diffusion de cette connaissance. Nous voudrons aussi connaître les vues de la population sur cette connaissance. Pour ce faire, nous tiendrons, au printemps 2002, des audiences publiques dans divers lieux au Canada. »*

Et ce défi était effectivement de taille. C'est une chose en effet de rendre disponible, de manière passive, une série d'informations, tant sous la forme des comptes-rendus de nos audiences que de rapports de recherche. C'en est une autre d'avoir les moyens de faire connaître largement cette information. Et c'en est encore une autre que de saisir le pouls de la société canadienne.

Pour transmettre l'information aux Canadiens, nous avons choisi d'utiliser pleinement notre site Internet y logeant tous nos documents au fur et à mesure qu'ils étaient prêts. Pour stimuler sa circulation, nous avons utilisé deux outils principaux. Le premier, conventionnel, celui des médias : attirer le plus possible une couverture de presse dans le but de faire connaître la nature de nos travaux, voire tout simplement l'existence de ce Comité. Dans la même veine, certains membres du Comité ont aussi participé à des conférences, à des tables rondes, à des lignes ouvertes. Le second moyen, qui nous est apparu essentiel pour faire connaître nos travaux, a été la publication, en mai 2002, d'un document de discussion. Ce document énonçait un certain nombre de nos conclusions préliminaires de recherche autour de huit questions clés, proposait un certain nombre d'options de politiques publiques, et identifiait des questions pour animer les débats publics. En plus de viser à transmettre nos connaissances et de susciter l'intérêt de la population, ce document avait pour objectif

de servir de toile de fond aux audiences publiques que nous avons tenues dans diverses villes du pays aux mois de mai et juin 2002.

Seul l'avenir dira si, et dans quelle mesure, nous avons réussi à faire connaître nos travaux et surtout à augmenter le niveau de connaissances sur le cannabis dans la population. Nous n'avions pas les moyens financiers de mener une vaste campagne d'information publique non plus que de mener une enquête d'opinion avant et après la publication du document de discussion pour déterminer si nous avions eu un impact auprès de nos concitoyens.

Il est beaucoup plus difficile de saisir l'état de l'opinion, des attitudes et des représentations de la population. Les moyens traditionnels de l'enquête quantitative sur un échantillon représentatif de la population étaient trop dispendieux. Les sondages présentent aussi toute une série de limites dont nous discuterons plus amplement plus loin. Par contre, nous avons commandé une étude qualitative par groupes de discussion dont nous présenterons les résultats dans ce chapitre. Nous rapporterons aussi les résultats de sondages dont nous avons pu prendre connaissance. De plus, de nombreux citoyens nous ont écrit des lettres ou envoyé des courriels et un certain nombre ont participé à nos audiences publiques. On ne peut évidemment en tirer de conclusions : il est probable que seuls ceux que la question intéresse de près nous auront écrit, quel que soit le côté où penchent leurs préférences. Nous en citerons des extraits en insistant sur l'importance de ne rien conclure quant à la représentativité de ces opinions.

On ne saurait faire état de l'opinion et des représentations que se font les Canadiens des drogues en général, du cannabis en particulier, sans examiner aussi le rôle des médias dans la construction de ces représentations. Au cours des dernières années, suite entre autres aux travaux de ce Comité, divers journaux et magazines canadiens ont réalisé des reportages ou écrit des commentaires éditoriaux sur la question. Ce sera l'objet de la première section de ce chapitre. La suivante présente les résultats d'enquêtes et de sondages, incluant celle que nous avons commandée et certaines qui ont été menées dans certaines provinces. La dernière section porte sur notre compréhension de ce que les Canadiens nous ont dit.

LES MÉDIAS

Au début du siècle, les médias ont joué un rôle important dans la construction de la « panique » morale sur les drogues illicites. Ce fut d'abord le « péril jaune » et la crise de l'opium au début du XXe siècle, principalement à Vancouver.[1]

[1] Sur cette question, voir les analyses de Giffen, P.J. et coll., (1991) *Panic and Indifference. The Politics of Canada's Drug Laws.* Ottawa :Canadian Centre on Substance Abuse ; Boyd, N. (1991) *High Society : Illegal and Legal Drugs in Canada.* Toronto : Key Porter Books.

[Traduction] *« La tolérance pour l'habitude de fumer de l'opium s'est maintenue aussi longtemps que celles des Britano-Colombiens pour les Chinois. Au cours des premières années du XXe siècle, le surplus de main d'œuvre et le sentiment antiasiatique dans la population se sont tous deux accentués. (…) Au cours des cinq premières années du XXe siècle, il y avait sur pratiquement toutes les premières pages du « Province » de Vancouver des caricatures racistes mettant en garde les lecteurs contre le péril jaune, dépeignant la façon dont la Colombie-Britannique allait être absorbée par les Chinois et annonçant l'arrivée d'un autre bateau de Chinois. »* [2]

Ainsi, ce texte du *Canadian Magazine* en 1900 :

[Traduction] *« Il était évident qu'il (le serviteur chinois) avait eu sa dose et plus encore, car on trouve à Vancouver des fumeries chinoises d'opium où se pratiquent des habitudes infâmes et indicibles. Peu importe l'apparence soignée et docile de votre Chinois, peu importe la douceur de sa voix et ses manières invitantes, vous pouvez être certain de le trouver, chaque samedi soir, dopé dans son antre et rêvant sous les volutes du pavot. »* [3]

Ce fut ensuite le fléau de la cocaïne à Montréal dont témoigne cet article du Witness de Montréal de 1910 :

« Ce fléau de la cocaïne n'existe que depuis quelques temps dans cette ville. C'est un mal réel, une plaie sociale, et il se répand de façon si terrible qu'il est temps que la société s'en préoccupe. L'alcoolisme et la morphinomanie ne sont rien en comparaison de l'habitude de la cocaïne. Celle-ci est le moyen auquel on a recours en vue de la séduction de nos jeunes filles et de la démoralisation de nos jeunes gens (…) ceux qui connaissent ce qu'est réellement la cocaïne et les malheurs qu'elle occasionne, ceux-là, s'ils permettent l'usage de cette drogue, nuisent à la société elle-même dans la mesure la plus large possible. » [4]

Cette vision de la déchéance et de la dégénérescence de la classe ouvrière, et plus largement de la civilisation anglo-britannique et chrétienne, sera ensuite relayée par les mouvements de tempérance. Un personnage important de l'histoire des femmes au Canada, Emily Murphy, allait jouer un rôle prédominant au cours des années 20 dans l'articulation de cette vision d'apocalypse. Écrivaine et journaliste, elle a été présidente du *Canadian Women's Press Club* (1913-1920), première présidente de la Fédération des instituts féminins, membre du Conseil national des femmes du Canada, avant de devenir juge en Alberta. Elle s'est aussi battue pour que la constitution canadienne reconnaisse les droits des femmes. Et elle a été une activiste infatigable dans la lutte contre les drogues. Dans une série de textes publiés dans le magazine *MacLean* en 1920, elle s'en prenait au « fléau » de la drogue.

---

2 Boyd, N., *op. cit.*, pages 27-29.

3 Cité dans Giffen, P.J., *op. cit.*, page 61.

4 Cité par McKenzie King dans Hansard, Chambre des Communes, 26 janvier 1911, pages 2641-2642.

> [Traduction] *« Peu importe la façon dont une drogue est consommée, elle provoque la dégradation morale et affaiblit la volonté. Peu importe leur statut social, les consommateurs invétérés deviennent des dépravés. Ils sont tous menteurs et la plupart d'entre eux deviennent malhonnêtes. S'ils sont privés de drogues, ils feront tout pour en obtenir, même si cela implique le vol ou la prostitution. L'abstinence de consommer au cours d'une longue période provoque une douleur semblable à celle d'un clou qui enfonce la peau. »* [5]

En 1922, dans son livre *The Black Candle*, elle s'attaquait aussi à la marijuana qu'elle décrivait dans ces termes :

> [Traduction] *« Les personnes qui font usage de cette drogue fument les feuilles séchées de la plante, ce qui leur fait perdre complètement la raison. Elles n'ont plus aucun sens moral et, sous l'influence de cette substance, deviennent insensibles à la douleur. Elles sont alors en proie à la folie furieuse et capables de tuer ou de se livrer à toutes sortes de violences sur d'autres personnes, en utilisant des méthodes d'une cruauté barbare, et comme nous l'avons dit, en ne faisant preuve d'aucun sens moral. Lorsqu'elles sont sous l'influence de cette drogue, ces victimes représentent les pires conditions de vie imaginables. Elles sont privées de toute volonté et sont mentalement déficientes. Si cette substance est consommée en trop grande quantité, elle provoque ultimement la mort du toxicomane. »* [6]

Au delà de l'emphase verbale de ces divers textes et du racisme envers les Asiatiques, on peut constater une certaine ressemblance entre les discours de l'époque et certains discours contemporains sur les drogues : elles s'attaquent aux racines morales de la société et en particulier à la famille, elles menacent la jeunesse, elles causent la criminalité et la violence ; les dealers sont partout, surtout près des écoles, prêts à tout pour assurer la reproduction de leur clientèle ; et les drogues, nécessairement, mènent à la toxicomanie.

Ce n'est pas dire pour autant que les articles publiés dans les journaux soient la raison principale pour laquelle on a criminalisé les drogues. Ce n'est pas dire non plus que ce qui était écrit finissait par être ce qu'on croyait. Néanmoins, plusieurs analystes de l'évolution des lois sur les drogues au Canada s'entendent pour souligner l'importance des médias dans l'architecture des lois canadiennes sur les drogues.

Quelles sont les orientations des médias canadiens sur les drogues aujourd'hui ? Nous n'avons pas fait une analyse de l'ensemble de la couverture de presse sur les drogues au Canada. L'exercice eut sans doute été intéressant d'un point de vue sociologique pour identifier les notions clés, saisir les modes de représentation qui concourent à former l'opinion publique. Nous nous satisfaisons ici d'examiner deux grands types d'articles de presse. Les premiers sont de l'ordre de la nouvelle judiciaire, les seconds sont des reportages de fond et des commentaires éditoriaux.

Les articles de nouvelles traitant des drogues illicites concernent le plus souvent les opérations policières : descentes, saisies, arrestations de trafiquants et

---

[5] Murphy, E., (1920) « The underground system. » *MacLeans*, 15 mars 1920.

[6] Murphy, E., (1922) *The Black Candle*. Toronto : Thomas Allans, pages 332-333.

démantèlement de réseaux reliés au crime organisé. L'exemple contemporain le plus connu a sûrement trait au coup de filet réalisé en 2001 au Québec lors de l'arrestation de plus de 70 membres des Hells Angels dont on sait qu'ils sont entre autres impliqués dans le trafic de stupéfiants. Au delà, ce sont, mois après mois, des nouvelles saisies de kilos voire de centaines de kilos de drogues, de plus en plus souvent de marijuana.

Comment ces informations contribuent à former l'opinion publique sur les drogues, quels en sont les impacts sur les représentations que s'en fait le public, nous l'ignorons. Il est probable cependant que ces articles donnent à penser que le « problème de la drogue » est d'abord et avant tout un problème de criminalité organisée. Mais si l'on pouvait avoir l'impression, disons jusqu'au milieu des années 1980, que le cannabis était un problème exporté au Canada à partir d'autres pays, il est vraisemblable que l'augmentation des articles traitant des saisies de plantations domestiques – plutôt que de cargaisons provenant de l'étranger – mène de plus en plus à penser le cannabis comme un problème domestique.

D'autres articles de nouvelles concernent la relation entre drogues et criminalité, notamment la prostitution, les cambriolages dans les résidences, ainsi que les « incivilités » relatives aux jeunes de la rue et à l'itinérance. On continue en effet à associer au moins pour partie ces activités à la drogue. Pour la prostitution de rue, c'est le fait que les personnes, principalement les femmes, pratiquant la prostitution soient souvent amenées à cet extrême pour « payer » leur dose. Pour les cambriolages résidentiels, c'est la même raison mais le genre des auteurs change : il s'agit dans ce cas de jeunes hommes. Et pour les jeunes dans la rue, c'est le fléau de l'injection et donc de la transmission du SIDA qui préoccupe principalement. Rien de cela ne concerne directement le cannabis. Sauf pour les écoles. Il n'est probablement pas une grande – et une moins grande – ville canadienne qui n'ait, au cours des quelques dernières années, vu une opération policière dans les écoles. Ces opérations suscitent le plus souvent deux types de réactions, toutes deux fondées sur l'indignation : pour les uns c'est l'indignation de voir que les drogues soient à ce point intégrées dans les écoles, pour les autres c'est l'abus de pouvoir policier et le non-respect des droits des jeunes.

On a vu, au cours des quelques dernières années, des reportages de fond tant dans les journaux que dans les médias électroniques. La série préparée par le journaliste Dan Gardner du *Ottawa Citizen*, en 2000, et largement reprise par tous les quotidiens de la chaîne Southam, est sûrement la plus connue. Dans cette série de 10 articles, le journaliste expliquait pourquoi la « guerre à la drogue » est un échec patent. Il commençait sa série ainsi :

> [Traduction] *« La campagne globale de l'Oncle Sam pour en finir avec l'abus des drogues a augmenté le pouvoir des criminels, corrompu les gouvernements et diminué les libertés civiles, et il y a plus de toxicomanes que jamais auparavant. Le 6 juin 1998, Kofi Annan, le secrétaire général des Nations Unies, a reçu une lettre étonnante. « Nous croyons », disait-elle, « que la guerre globale contre les drogues cause plus de dommages que les drogues elles-mêmes. » Cette lettre était signée par des hommes d'état, des politiciens, des universitaires et d'autres personnalités. Javier Perez de Cuellar, l'ancien secrétaire général de l'ONU était parmi les signataires. Tout comme George Shultz, l'ancien Secrétaire*

d'état américain et Joycelyn Elders, l'ancienne Médecin chef aux États-Unis. Des prix Nobel tels Milton Friedman et Adolfo Perez Esquivel d'Argentine, quatre anciens présidents et sept anciens ministres d'Amérique latine étaient parmi les signataires. Et quelques éminents Canadiens aussi. Ils ont ajouté que les politiques sur les drogues que le monde a suivies depuis quelques décennies sont un échec aux conséquences dévastatrices. Tenter d'éliminer l'abus de drogues par la prohibition a créé une industrie valant 400 milliards $ US. « soit environ 8% du commerce international. » (...) Cette déclaration coïncidait avec le début d'une assemblée générale des Nations Unies sur les problèmes globaux des drogues. Les gouvernements participant à cette assemblée semblaient unanimes à penser que la meilleure manière de combattre l'abus de drogues était d'en bannir la production, la vente ou la possession. (...) Mais la lettre adressée à M. Annan a démontré que leur point de vue ne fait pas l'unanimité. En fait, un nombre croissant de leaders mondiaux et d'experts pensent que la guerre à la drogue n'est rien de moins qu'un désastre humanitaire.»[7]

Cette série d'articles faisait en quelque sorte écho à des commentaires éditoriaux parus dans le même Ottawa Citizen, en 1997, demandant la décriminalisation des drogues.[8] L'éditorialiste écrivait notamment ceci dans le second de la série : « *L'histoire récente de l'application des lois sur les drogues, au Canada aussi bien qu'aux États-Unis, est l'histoire d'un échec. Les impôts financent grassement la répression. Les pouvoirs policiers augmentent au détriment des libertés civiles. Les gangs criminalisés sont de plus en plus riches. Et l'usage de drogues continue, peu importe.* »

En 1998, le Globe and Mail de Toronto en faisait autant, sous le titre « *Que fument les leaders du G8 ?* » écrivant entre autres : [Traduction] *« La prohibition ne marche pas et ne peut pas marcher, et ses coûts sont nettement supérieurs à ceux d'une politique d'accessibilité adéquatement supervisée et contrôlée. Puisque l'élimination des drogues n'est pas une option, les leaders du G8 auraient dû se demander comment minimiser les méfaits des drogues. En l'état actuel, leurs politiques maximisent les dégâts.»* Dans une série de deux éditoriaux, le Globe and Mail reprenait l'exercice en juillet 2001, recommandant la décriminalisation du cannabis.. Le Vancouver Sun en faisait autant en octobre 1998 et le National Post prenait aussi position pour mettre fin à la prohibition du cannabis. Enfin, plus récemment encore, dans les suites des événements tragiques du 11 septembre 2001, l'éditorialiste du Citizen répondait à ceux qui laissaient entendre que l'argent du trafic de drogues sert à financer les actions terroristes. Il disait ce qui suit :

« En matière de lutte antidrogues, la plus récente menace soulevée par le solliciteur général Lawrence MacAulay et d'autres personnes concerne l'hypothèse selon laquelle les terroristes utiliseraient les produits du trafic de la drogue pour financer leurs activités diaboliques. Si c'est le cas, il est facile de voir pourquoi. Comme tout véritable crime, le terrorisme fait des victimes plutôt que des clients satisfaits. Il ne s'agit donc pas exactement d'une entreprise autofinancée. En revanche, le commerce de la drogue permet de réaliser constamment des profits parce que les transactions auxquelles il donne lieu sont tellement satisfaisantes pour le vendeur comme pour l'acheteur que ces derniers risquent la prison pour

---

[7] Gardner, D., « Why the war on drug has failed : Uncle Sam's war. » *Ottawa Citizen*. 5 septembre 2000.

[8] Editorial, «Decriminalizing Drugs », *Ottawa Citizen*, 12 avril 1997, 14 avril 1997, 15 avril 1997 et 16 avril 1997.

> *pouvoir les mener à bien. (…) (…) non seulement la lutte antidrogues entraîne le mépris de la loi et menace la sécurité publique, mais elle aide à financer les terroristes et leur permet de passer d'un pays à un autre. Et les gens veulent poursuivre cette lutte ? J'estime que, puisque toute décision vertueuse doit se prendre au nom de la vertu, il faut abolir les lois sur les drogues pour des raisons morales. Mais faites abstraction de mon dégoût pour le paternalisme. Si la lutte antidrogues diminue nos chances de gagner la lutte contre le terrorisme, alors elle fait sûrement plus de mal que de bien. »*[9]

L'intérêt de ces prises de position et de ces articles de fond tient à divers éléments. Premièrement, ils marquent un changement majeur par rapport aux positions soit plus timides soit plus simplement en faveur de la prohibition qui dominaient depuis le début du siècle. Ils s'inscrivent aussi dans une interrogation constante du rôle de l'État et de l'à-propos des dépenses publiques. Ils marquent aussi, en corollaire, une préoccupation plus grande pour les libertés individuelles.

Quel en est l'impact auprès de l'opinion publique, nous l'ignorons. Traduisent-ils des sentiments largement répandus dans la population ou, au contraire, sont-ils en porte-à-faux, nous ne sommes pas en mesure de le dire. Une seule chose nous paraît relativement certaine : la plupart des grands médias canadiens ont pris une distance critique appréciable face aux politiques de prohibition.

ENQUÊTES ET SONDAGES

Selon l'un de nos témoins :

> *« D'après les sondages effectués au cours des dix dernières années, notamment par Santé Canada, nous savons que les deux tiers des Canadiens considèrent que la consommation de cannabis ne devrait pas être punissable d'emprisonnement et qu'environ la moitié des Canadiens préconisent explicitement la décriminalisation ou la déjudiciarisation de la consommation de cannabis. Cette opinion persiste depuis 25 ans. Autrement dit, les législateurs et les décideurs politiques n'ont tenu aucun compte jusqu'ici du message que l'opinion publique leur adresse depuis un quart de siècle. »*[10]

L'une des limites importantes des sondages d'opinion tient à leur côté superficiel : les questions sont souvent insérées dans des enquêtes plus générales portant sur une diversité de sujets, il y a peu de place pour poser des questions multiples, et on explore rarement le sens des termes. Ainsi, par exemple, les termes légalisation ou décriminalisation n'ont pas nécessairement le même sens pour tous les répondants. Mais les sondages généralistes ne sont pas en mesure, ou prennent rarement les

---

[9] William Robson, « Combien de banlieues devront flamber à cause de la lutte antidrogues ? » *Ottawa Citizen*, 17 mai 2002.

[10] Dr Benedikt Fischer, professeur, école des sciences de la santé publique, Université de Toronto, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la 37e législature, 17 septembre 2001, fascicule 6, pages 13-14.

moyens, de révéler ces différences. Si l'enquête pose une seule question portant sur le cannabis, du genre «êtes-vous en faveur de la décriminalisation de la possession de petites quantités de cannabis ?», on ne sait pas ce que les répondants pensent en entendant «décriminalisation» et «petites» quantités. Pour certains, décriminalisation peut signifier aucune pénalité ; pour d'autres ce sera une amende. Et la différence entre 5 grammes et 30 grammes est énorme.

Comme les médias, et de manière toute aussi complexe, les sondages participent à la construction des représentations publiques. Comme pour les médias, il est difficile de déterminer dans quelle mesure ils contribuent à modifier les attitudes et encore plus les comportements. Ces quelques réserves émises, nous fournissons dans les paragraphes suivants un échantillon de données provenant de diverses enquêtes.

Dans l'enquête nationale sur l'alcool et les drogues de 1994, les répondants étaient invités à donner leur opinion sur les politiques concernant le cannabis : 27 % étaient d'avis que la possession de petites quantités devrait être légale ; 42 % qu'elle devrait être illégale mais ne faire l'objet d'aucune pénalité ou d'une amende seulement ; et 17 % que la possession de cannabis devrait entraîner une peine de prison potentielle dans le cas d'une première infraction. Les hommes et les plus jeunes sont plus nombreux à favoriser la légalisation du cannabis, de même que les résidents de la Colombie-Britannique, du Québec, de l'Alberta et de l'Ontario.[11]

En 2000, le National Post relevait les résultats d'un sondage voulant que près des deux tiers des Canadiens soient en faveur de la décriminalisation de la marijuana et que la possession de petites quantités pour usage personnel soit punie par une amende.[12]

Plus récemment encore, dans le cadre d'un sondage effectué en mai 2001, 47 % des Canadiens se sont déclarés en faveur de la légalisation de la marijuana, en hausse par rapport aux 31 % de 1995 et aux 26 % de 1975.[13]

Au Québec, en 2001, une enquête plus fine a été menée sur les perceptions de la population à partir d'un échantillon de 2253 répondants (taux de réponse de 70 %).[14] L'enquête portait uniquement sur les drogues, la toxicomanie et le VIH, et mesurait les connaissances, la perception de la dangerosité, la perception à l'égard des personnes toxicomanes, et les politiques et mesures possibles. L'intérêt d'une étude de ce type est que, ne portant que sur les questions relatives aux toxicomanies et aux drogues, elle permet d'approfondir et clarifier davantage certaines questions.

Cette étude révèle que la majorité (66 %) de la population pense que la consommation de drogues est en augmentation. Elle démontre aussi que « *le cannabis est dans une classe à part* » quant à la perception de sa dangerosité puisque «*seulement une personne sur quatre juge cette substance illicite dangereuse dès la première consommation, ce qui est*

---

11 Centre canadien de lutte contre l'alcoolisme et les toxicomanies (1999) *Profil canadien. L'alcool, le tabac et les autres drogues.* Ottawa : auteur, pages 214-215.

12 National Post, « Two-thirds favour decriminalizing pot. » 15 mai 2000.

13 Julian Beltrame, « Reefer Madness : The Sequel. » *MacLean's.* 6 août 2001, vol 114, pages 22-25.

14 Hamel, D. et coll., (2001) *Perceptions de la population québécoise en lien avec les programmes de prévention de la toxicomanie et du VIH.* Québec : Institut national de santé publique du Québec.

moins que l'opinion rapportée pour le tabac qui est pourtant licite. De plus, le cannabis est le seul produit qu'un nombre relativement important de sondés considèrent comme jamais dangereux pour la santé. (...) les gens le considèrent moins dangereux que le tabac. »[15] Les enquêtés perçoivent aussi que le cannabis est la substance la moins susceptible de mener à la dépendance : environ 15 % pensent que le cannabis crée la dépendance dès qu'on l'essaie alors que pour plus de 40 % des répondants il faut en consommer chaque jour et que 8 % disent que le cannabis ne crée jamais de dépendance.[16]

Eu égard aux opinions sur les politiques publiques, l'étude démontre une nette préférence pour les mesures de prévention et d'éducation par rapport aux mesures de contrôle et de répression. À la question de savoir quelles mesures seraient susceptibles d'enrayer les problèmes de la drogue, près de 35 % pensent que la vente contrôlée de la marijuana et du haschich permettrait de réduire les méfaits. Selon les auteurs, la population montre «*une ouverture sans équivoque à une certaine forme de légalisation du haschich et de la marijuana. Plus de 90 % d'entre eux seraient d'accord à ce qu'on permette à certains grands malades de recevoir ces substances sur prescription pour soulager leurs douleurs. Beaucoup moins de gens mais tout de même une majorité (60 %) seraient prêts à autoriser la consommation de ces drogues sous certaines conditions comme peut-être l'alcool.* »[17] Par ailleurs, moins de 40 % pensent que la loi actuelle contribue à empêcher les gens de consommer (et environ 60 % sont plutôt ou tout à fait en désaccord avec cet énoncé).[18]

En Ontario, l'enquête en milieu scolaire a aussi examiné les perceptions des étudiants sur le risque perçu et la désapprobation eu égard à la consommation de marijuana. Le tableau suivant présente les résultats.

Perceptions des étudiants ontariens, niveau secondaire 1989-2001 [19]

	1989*	1991	1993	1995	1997	1999	2001
Désapprouvent l'expérimentation							
Total	40,8 %	43,2 %	37,1 %	28,8 %	23,4 %	26,0 %	28,6 %
7e	58,9 %	58,0 %	48,6 %	44,9 %	40,8 %	44,3 %	48,2 %
9e	38,0 %	48,3 %	38,8 %	30,1 %	21,6 %	25,7 %	23,7 %
11e	33,0 %	32,5 %	30,2 %	16,3 %	13,2 %	18,2 %	19,4 %
13e	26,7 %	28,4 %	27,7 %	25,7 %	18,8 %	13,4 %	20,7%
Désapprouvent la consommation régulière							
Total	61,0 %	60,8 %	55,9 %	47,2 %	45,2 %	43,1 %	41,7 %
7e	73,7 %	72,1 %	66,6 %	62,3 %	58,7 %	63,6 %	64,0 %

[15] *Ibid.*, page 3
[16] *Ibid.*, page 27.
[17] *Ibid.*, page 4
[18] *Ibid.*, page 38.
[19] Adlaf, E.M., and A. Paglia (2001), *Drug Use among Ontario Students 1977-2001. Findings from the OSDUS*, Toronto: Centre for Addiction and Mental Health.

	1989	1991	1993	1995	1997	1999	2001
9e	59,8 %	62,5 %	54,3 %	48,6 %	41,1 %	43,6 %	34,3 %
11e	54,9 %	52,4 %	50,9 %	33,6 %	30,9 %	31,2 %	29,8 %
13e	50,1 %	56,1 %	51,1 %	48,6 %	42,6 %	32,8 %	40,7 %
Associent un risque élevé à l'expérimentation							
Total	27,8 %	30,7 %	27,3 %	18,5 %	17,1 %	18,4 %	18,6 %
7e	39,2 %	37,0 %	35,3 %	30,7 %	26,2 %	28,4 %	27,0 %
9e	29,7 %	35,4 %	29,3 %	18,6 %	14,3 %	16,6 %	18,5 %
11e	18,0 %	25,2 %	21,8 %	10,5 %	12,8 %	15,2 %	11,1 %
13e	19,2 %	21,2 %	19,7 %	14,2 %	16,4 %	12,5 %	17,7 %
Associent un risque élevé à la consommation régulière							
Total	75,4 %	73,3 %	69,3 %	58,1 %	56,1 %	52,0 %	48,2 %
7e	72,6 %	72,1 %	69,8 %	67.6 %	60,5 %	63,6 %	61,1 %
9e	79,1 %	74,0 %	73,7 %	60,8 %	59,3 %	53,1 %	47,8 %
11e	74,7 %	73,9 %	66,9 %	50,8 %	49,4 %	44,9 %	36,8 %
13e	73,3 %	73,1 %	63,4 %	50,6 %	55,7 %	45,2 %	47,8 %

Ces résultats démontrent que, sur tous les indicateurs, les attitudes des étudiants ontariens de niveau secondaire sont moins alarmistes, ou plus libérales, selon le point de vue que l'on adopte. Ainsi, ils sont moins nombreux en 2001 qu'en 1989 à désapprouver la consommation expérimentale (une ou deux fois) de cannabis ou la consommation régulière. Ils sont cependant toujours plus nombreux à désapprouver la consommation régulière que la consommation occasionnelle. Le niveau de désapprobation diminue plus le niveau scolaire augmente. De même, les étudiants ontariens sont moins nombreux à associer un risque élevé à la consommation de cannabis en 2001 qu'en 1989, mais ils demeurent près de trois fois plus nombreux à associer un risque élevé à la consommation régulière qu'à la consommation expérimentale. Notons tout de même que la proportion de ceux qui associent un risque élevé à la consommation régulière de marijuana forme maintenant moins de la moitié des élèves, comparativement aux trois quarts en 1989.

L'ensemble de ces données s'accordent dans une large mesure avec les résultats de l'étude que le Comité a commandée à la firme Léger Marketing.[20] Cette étude qualitative par groupes de discussion avait pour objectif de déterminer s'il était possible d'identifier les éléments qui pourraient fonder un consensus social sur l'usage du cannabis. Plus spécifiquement, cette étude visait à cerner la perception globale à l'égard des drogues en général et du cannabis en particulier, les images associées au cannabis, les attitudes et comportements à l'égard de l'usage récréatif, les craintes et préjugés, la connaissance du cadre législatif et les attentes à l'égard d'une politique publique sur l'usage du cannabis à des fins récréatives. Pour ce faire, la firme a réalisé 16 groupes de discussion ainsi que 15 entrevues en profondeur à Montréal, Trois-Rivières, Halifax,

[20] Léger Marketing (2002) *Étude exploratoire auprès des Canadiens sur l'usage du cannabis.* Montréal : auteur. Disponible en ligne sur le site du Comité.

Winnipeg, Vancouver, Toronto et London. Au total, plus de 130 personnes ont participé à cette étude. Dans chaque ville, il y avait au moins deux groupes de discussion, un avec des adultes de plus de 18 ans et l'autre avec des jeunes de 14 à 17 ans.

Spontanément, les participants aux groupes de discussion ne mentionnaient pas les drogues parmi leurs préoccupations quotidiennes, celles-ci se centrant plutôt sur la santé, l'éducation, l'emploi et la pauvreté. Lorsque le sujet était abordé par les enquêteurs, les participants nommaient d'abord les activités criminelles reliées à la vente et à l'importation de drogues comme préoccupation principale plutôt que l'usage par les Canadiens. Dans certaines villes, (Montréal, Vancouver), les participants exprimaient aussi une inquiétude sur l'impact de la présence de drogues illicites dans certains quartiers sur la qualité de vie et la sécurité.

Interrogés sur le cannabis, les participants faisaient presque systématiquement et spontanément une distinction entre des drogues douces (cannabis, haschich) et des drogues dures (cocaïne, héroïne), plusieurs considérant même le terme drogue inapproprié pour parler du cannabis. Cette distinction reposait sur la base de deux éléments majeurs : la composition et les effets. Les drogues dures sont davantage associées aux produits chimiques avec des effets destructifs, notamment une propension plus grande à développer la dépendance. Le cannabis et ses dérivés sont associés à des plantes, à des produits naturels, et le risque de dépendance est presque nul, sauf chez des personnes ayant des prédispositions ou des vulnérabilités particulières. La comparaison avec l'alcool était fréquente : on peut consommer de l'alcool de manière raisonnable sans danger, et seule une petite partie des consommateurs développe des problèmes de dépendance. On n'associait pas non plus le cannabis à la criminalité : « *I can't picture a guy robbing the corner store to buy himself a joint. This is something heroin addicts would do. First, pot is cheap, second it doesn't make you want it desperately.* » La seule exception plus présente au Québec qu'ailleurs, était l'association avec la criminalité organisée, les bandes de motards.

Tandis que l'usage de drogues « dures » s'inscrit dans un univers de détresse morale et physique et déchéance sociale, les participants associaient généralement une dimension de convivialité et de plaisir à l'usage du cannabis, qu'on consomme surtout dans des occasions sociales, comme l'alcool.

En toute logique, l'usage récréatif du cannabis était généralement bien accepté : « *it doesn't bother me that people do marijuana. As long as they are aware of their decision and what they are doing, I respect it.* » De fait, spontanément, plusieurs participants dans chaque groupe évoquaient leurs propres expériences de consommation passée ou actuelle : « *I sometimes smoke pot and it doesn't keep me from being a productive guy at work or a good family man.* » Et comme pour l'alcool, ce sont davantage les notions d'abus et de responsabilité qui marquent la différence, quoiqu'on soit plus dur envers les abus d'alcool qu'on associe à la violence. « *I used to go out to bars a lot. Every night there would be a fight. A guy gets drunk and then starts insulting somebody else or feels another is flirting with his girlfriend. At one point punches get thrown around. But you know what ? I have never seen a guy*

stoned on pot go nuts and want to knock somebody out. » S'ils n'associaient pas la consommation de cannabis ni à la violence ni à la criminalité, les participants se montraient cependant préoccupés par la conduite sous l'influence de cannabis. Enfin, les participants n'associaient pas la consommation de cannabis à une classe déterminée de la population : ce sont les jeunes mais aussi des professionnels, des artistes, des avocats, des fonctionnaires...

Les chercheurs n'ont pas observé de clivage générationnel à l'égard de l'usage récréatif du cannabis. Si un clivage existe, il reposerait davantage sur des caractéristiques socioprofessionnelles : les citoyens moins scolarisés et résidant en milieu rural semblent démontrer une plus grande résistance. De même, les personnes s'opposant à la consommation récréative de cannabis le feraient plutôt sur des bases morales, parfois même religieuses. Autre clivage, les femmes ayant des enfants d'âge scolaire, se disaient très préoccupées par la grande disponibilité de la marijuana en milieu scolaire. « *Qu'ils légalisent ou pas moi ça ne change rien. Moi, tout ce que je veux c'est que les drogues ne soient pas accessibles aux enfants. Qu'ils en vendent au primaire moi ça m'enrage parce que ça les rend dépendants très jeunes.* »

Comme les sondages d'opinion publique discutés plus tôt l'ont démontré, les participants appuyaient largement la légalisation du cannabis à des fins thérapeutiques. Toutefois, certains souhaitaient qu'une structure claire de distribution soit établie dans les établissements de soins et qu'on puisse déterminer les doses adéquates selon l'intensité de la douleur.

En général, les participants estimaient qu'une consommation occasionnelle n'a pas d'effets néfastes sur la santé. Faisant spontanément la comparaison avec l'alcool et le tabac, ils considéraient que le cannabis n'est pas la plus dangereuse des trois substances. De même, la majorité ne craignaient pas l'accoutumance au cannabis, soulignant que ça dépend de la maturité et de la fréquence de la consommation. « *This is the key question. I don't think you can get hooked on it really. Not as much as booze or nicotine for sure. But that's the kind of proof or medical evidence I would like to have if you want me to make up my mind on it.* » Les participants ne pensaient pas non plus que le cannabis pousse inexorablement à la consommation d'autres drogues, l'utilisation de drogues « dures » étant liée davantage à la personnalité et à la maturité de l'usager qu'aux caractéristiques du cannabis lui-même.

Le guide d'entretien demandait aux participants de réagir à deux données de recherche : la proportion de Canadiens qui ont consommé au cours des 12 derniers mois est d'environ 10 % et il se fait environ 30 000 mises en accusation par année pour possession simple de cannabis. Dans les deux cas, les participants étaient incrédules. Sur la proportion de consommateurs, tous les participants pensaient qu'il y en avait beaucoup plus : « *Ça me surprend que ça soit juste 10 % de la population, qui en consomme. Je m'attendais plus à 50 % ou 60 %.* » Inversement, sur le nombre de mises en accusation, les participants étaient unanimes à penser que les efforts des services policiers devraient plutôt porter sur la lutte aux réseaux criminels : « *30 000 people charged per year seems like a waste of taxpayers money if just for possession. It's a lot of money to prosecute and they all get thrown*

out anyway... » « *Quand on pense à d'autres crimes beaucoup plus importants, quand on pense à l'encombrement du système judiciaire, je trouve ça ridicule.* » Néanmoins, les participants considèrent que le Canada est une société relativement tolérante à l'égard de l'usage récréatif du cannabis, du moins comparativement à d'autres pays : côté répressif on nomme spontanément les États-Unis, l'Arabie saoudite, et côté tolérant on pense à la Suisse et aux Pays-Bas, le Canada étant quelque part entre les deux.

Les entretiens se sont produits après que le Comité eut rendu public son document de discussion dans lequel il proposait un tableau comportant une série d'options de politiques publiques. Les participants aux groupes de discussion étaient d'abord invités à faire part librement de leurs opinions sur les politiques publiques préférées puis on leur soumettait ce tableau leur demandant d'y réagir.

Le discours des participants tendait majoritairement vers un positionnement entre la décriminalisation et la légalisation. Cette position se retrouvait principalement à Montréal, Toronto, Vancouver et Halifax, plus de participants préférant la légalisation avec contrôles gouvernementaux à Vancouver et Montréal qu'ailleurs « *The best option is decriminalization leaning towards government legalization. The worst option would be depenalization : to legalize without getting involved.* » Selon les participants, ces options permettraient d'augmenter la capacité d'informer sur les risques, la santé des usagers, la sécurité publique, le respect des droits et libertés individuelles et l'efficacité des dépenses publiques, et feraient diminuer le trafic illégal et l'implication du crime organisé. Par ailleurs, ils s'attendaient à une augmentation de la consommation récréative du cannabis mais ne pensaient pas qu'il y aurait nécessairement augmentation de l'abus ou de la consommation chez les jeunes. Au contraire, plusieurs étaient d'avis que la décriminalisation entraînerait un désintérêt chez les jeunes qui auraient perdu l'attrait du fruit défendu.

Il demeure un noyau dur, quoique minoritaire, qui estime que les lois actuelles ne sont pas assez sévères et que la société devrait se diriger vers une criminalisation accrue de l'usage récréatif de cannabis. Cette position se retrouvait notamment à Winnipeg chez les personnes de plus de 40 ans et à Trois-Rivières.

Enfin, les participants souhaitaient être informés et « éduqués » sur ce qui concerne l'usage du cannabis, notamment sur les connaissances scientifiques sur les effets à court et à long terme, sur les risques réels de dépendance et d'escalade, sur les moyens de protéger les enfants contre une consommation précoce, et sur les impacts de la décriminalisation sur la lutte au crime organisé.

Selon les auteurs de l'étude, les marqueurs suivants ressortent :

- La protection des jeunes et des enfants est au cœur de toute réflexion sur une politique publique sur le cannabis ;
- La décriminalisation de l'usage se dégage comme option privilégiée, permettant de reconnaître la réalité sociale en même temps que de se concentrer sur les « vrais » problèmes ;
- Un certain nombre de participants se sont exprimés en faveur de la légalisation, s'interrogeant cependant sur la nature et les modes de

contrôle relatifs à la production et aux normes de qualité, aux modes de distribution et de commercialisation, la mise en place de quotas pour éviter les abus.

Puisqu'il s'agit d'une enquête qualitative, nous ne pouvons généraliser ces résultats à l'ensemble de la population canadienne. Nos moyens financiers ne nous ont pas permis de mener une étude quantitative en profondeur sur un échantillon représentatif de la population, ce qui aurait pu permettre de valider ces «intuitions ». Néanmoins, nous pouvons au moins émettre les constats suivants : (1) ces résultats se rapprochent beaucoup des données résultant des sondages d'opinion ; (2) les convergences entre les groupes de discussion dans la plupart des villes et entre les groupes d'âge permettent de penser qu'il y a une certaine validité à ces intuitions.

ATTITUDES ET OPINIONS EXPRIMÉES AU COMITÉ

Des centaines de Canadiens de tous les coins du pays nous ont écrit, et plusieurs dizaines se sont exprimés lors de nos audiences publiques dans les régions. Ils parlaient en leur nom personnel, relatant leurs expériences, exposant leurs opinions, nous faisant part de leurs craintes. Ils représentaient des organisations : associations de défense des droits et libertés, clubs compassion de distribution de cannabis thérapeutique, organismes de traitement ou de prévention, associations de femmes. Ils étaient maires, chefs de police, usagers de cannabis médical, parents, éducateurs, médecins, avocats, consommateurs de cannabis, jeunes et moins jeunes. Ils parlaient souvent du cœur et leurs paroles nous touchaient. L'annexe 2 fournit la liste de toutes les personnes que le Comité a entendues au cours de ses audiences publiques. Nous tenons à remercier tous ceux et celles qui ont participé à nos travaux.

Il est impossible de présenter ici l'ensemble de ces contributions à nos débats, d'en faire ressortir l'extraordinaire richesse. Heureusement, les transcriptions des audiences du Comité resteront disponibles sur notre site internet. Nous nous contenterons d'un sommaire des opinions qui nous ont été transmises en réaction à notre document de discussion.

Soulignons d'abord que les citoyens qui ont pu exprimer leur avis étaient la plupart du temps très satisfaits de la rigueur de nos travaux et surtout très appréciatifs de l'occasion qui leur était donnée de participer à ce débat de société.

> *« J'ai suivi avec grand intérêt les délibérations du Comité spécial sur les drogues illicites et je voudrais remercier la personne qui a décidé de publier le mémoire de façon aussi complète et franche. Cela témoigne favorablement d'un gouvernement transparent, aspect vital pour le règlement du débat. »*

« Je voudrais tout d'abord féliciter le Sénat pour son Comité spécial sur les drogues illicites et son travail impartial et révolutionnaire sur la marijuana (...) »

« Je vous remercie de prendre le temps d'examiner ma présentation. Je voudrais féliciter le Comité du Sénat sur les drogues illicites de son excellent travail de recherche sur les faits et la critique des mythes qui existent sur les drogues illicites (...) »

« Tout d'abord, je voudrais remercier le Comité de ses compétences à séparer les faits de la propagande qui entoure cette question. (...) Je vous remercie de prendre le temps de recevoir la participation du public en la matière. Je souhaite seulement que cela ne tombera pas dans l'oreille d'un sourd comme ce fut le cas de la Commission Le Dain qui vous a précédés. Là encore, je crois que le Comité cherche à faire de son mieux pour le peuple canadien. (...) »

« C'est avec grand intérêt que j'ai lu votre Document de discussion sur le cannabis et la documentation qui l'accompagnait. Je me permets de vous féliciter pour votre disposition à lancer un débat public dans ce domaine de politique. (...) »

La plupart des personnes qui ont pris le temps de nous répondre ont aussi indiqué avoir trouvé le Document de discussion bien fait, utile et équilibré. Surtout, les répondants exprimaient leur accord avec les données de recherche que nous y avons présentées. Lorsque des réserves étaient exprimées elles concernaient diversement :

- Des biais dans l'interprétation des données : pour certaines personnes, il ne fait pas de doute que le cannabis est une drogue d'escalade ;
- Un côté trop prudent : dire que le cannabis est une drogue et qu'à ce titre il vaut mieux ne pas en consommer était perçu comme « politiquement correct » ;
- Un manque de compassion et de préoccupation pour les jeunes et les enfants.

Néanmoins, un certain nombre d'organismes et de personnes ont exprimé des réserves face à notre démarche et leur désaccord avec les conclusions énoncées dans notre document de discussion.

« Pour nous autres, ça ne fait pas de sens de légaliser une drogue avec tous les points d'interrogation et les faits concluants que l'on voit comme conséquences de l'usage du cannabis. Si c'était à refaire, je ne pense pas, avec les informations que l'on a présentement, que l'on voudrait légaliser la nicotine et même l'alcool. Du moment où l'on envisage de légaliser une drogue, on peut conclure qu'il y aura plus de disponibilité conséquemment plus de consommation, et conséquemment plus de problèmes. N'oublions pas que le cannabis n'est pas nocif parce qu'il est illégal mais plutôt que le cannabis est encore illégal parce que le cannabis est nocif. »[21]

---

[21] Mémoire de A. Maillet et C. Cloutier-Vautour soumis au Comité spécial du Sénat sur les drogues illicites, Moncton, 5 juin 2002.

[Traduction] *« Il est sain et utile de tenir un débat public informé, mais encore faut-il que la diversité des points de vue puisse s'exprimer. Malheureusement, ce n'est pas le cas lorsqu'il est question de l'usage non médical des drogues, où nous sommes constamment bombardés par les opinions de ceux qui croient que la seule manière de répondre au problème des drogues est d'accepter qu'elles sont inévitables, sinon normales. (…)*
Lorsqu'il est question de stratégies sur les drogues, on discute le plus souvent des dommages extrinsèques causés par l'illégalité des drogues illicites plutôt que des dommages intrinsèques dus à leurs effets chimiques sur le corps, particulièrement sur les fonctions cérébrales et le comportement. On ignore ainsi les effets dévastateurs des drogues sur les toxicomanes et leurs familles et l'on déplore plutôt les dommages d'un casier judiciaire sur l'estime de soi. De plus, les crimes contre la propriété et la violence causés par les usagers de drogues sont attribués à l'illégalité des drogues plutôt qu'au manque d'habitudes de travail et de capacité à gagner sa vie que cause l'usage de drogues. » [22]

[Traduction] *« Notre préoccupation face au Document de Discussion publié par le Comité tient essentiellement à l'effet que les politiques sur le cannabis auront sur les jeunes et les familles. (…) Nous suggérons au Comité qu'il serait plus utile de concentrer ses efforts sur la prévention que sur la réforme de nos lois sur les drogues. La Stratégie canadienne sur les drogues démontre que la prévention est la stratégie la plus efficiente. (…) Il se dit beaucoup de choses sur la supposée « guerre à la drogue » : si nous l'avons perdue, ce que nous devrions faire, et si nous étions engagés dans une guerre pour commencer. Le défi auquel fait face ce Comité n'est pas facile: recommander des politiques réalistes, concrètes, sur l'usage du cannabis. Nous somme convaincus que le Comité saura faire montre de prudence dans ses décisions, et que ses recommandations de politique seront innovatrices, tout en sachant résister à la « manie du cannabis ». Nous le devons à nos jeunes. »* [23]

« S'il vous plaît, mesdames et messieurs, ne vous fiez pas qu'aux recherches et aux experts. Beaucoup de rapports et d'experts sont largement financés par des promoteurs de la légalisation. Le THC, l'ingrédient actif du cannabis, peut être pris sous forme de pilules. Nous n'avons pas besoin de promouvoir le fumage sous une autre forme. (…) Si je peux vous faire une suggestion : 1. Il faut offrir plus de services de traitement ; 2. Il faut changer nos pratiques d'incarcération lorsqu'il s'agit de crimes commis sous l'influence des drogues et imposer le traitement ; et 3. Notre pays doit adopter une politique de tolérance zéro face aux drogues illicites et donner à nos policiers la capacité d'applique les lois et exiger des tribunaux qu'ils répondent à cette situation. Je vous en prie, ne donnez pas à nos enfants une autre manière d'échapper à la réalité. » [24]

Enfin, la plupart des personnes qui ont répondu au questionnaire nous ont aussi dit être en faveur soit de la décriminalisation, soit de la légalisation contrôlée du cannabis et de ses dérivés. Pour cette raison, nous devons demeurer très prudents quant à la signification des commentaires qui nous ont été transmis : il est probable en effet que la majorité de ceux qui nous ont écrit soient, pour des raisons personnelles,

---

[22] Real Women of Canada, mémoire soumis au Comité spécial du Sénat sur les drogues illicites, 6 juin 2002, pages 1-2.
[23] Focus on the Family (Canada) Association, mémoire soumis au Comité spécial du Sénat sur les drogues illicites, 14 mai 2002, page 2.
[24] Lettre de Mme Kathy Bédard, Prince Rupert, Colombie-Britannique, 15 mai 2002.

intéressés à ce que la législation actuelle soit modifiée vers une plus grande tolérance. Cette attitude colorait sans doute leur évaluation de notre Document et de la qualité de nos conclusions de recherche.

CONCLUSIONS

Quel est l'état de l'opinion publique au Canada ? Nous ne sommes pas en mesure de tirer des conclusions fermes sur cette question. Nous pensons cependant que :

Conclusions du chapitre 10	
Opinions sur le cannabis	➢ **Une opinion publique plus libérale qu'il y a dix ans sur le cannabis.** ➢ **Une tendance à penser que la consommation de cannabis est plus répandue qu'auparavant.** ➢ **Une tendance à considérer que le cannabis est plus disponible qu'auparavant.** ➢ **Une tendance à penser que le cannabis n'est pas une drogue dangereuse.** ➢ **Une préoccupation relativement importante face au crime organisé.** ➢ **Un soutien important pour la mise à disponibilité du cannabis aux fins thérapeutiques.**
Opinions sur les options de politique publique	➢ **Une tendance à favoriser la décriminalisation ou, dans une moindre mesure, la légalisation.** ➢ **Une attitude critique face aux mesures d'application de la loi pour simple possession de cannabis.** ➢ **Une préoccupation pour les enfants et les jeunes.**

VOLUME

VOLUME

2

Micromedia
ProQuest

20 Victoria Street
Toronto, Ontario M5C 2N8
Tel.: (416) 362-5211
Toll Free: 1-800-387-2689
Fax: (416) 362-6161
Email: info@micromedia.on.ca

Senate Sénat

CANADA

CANNABIS :

OUR POSITION FOR A CANADIAN PUBLIC POLICY

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

VOLUME II : PART III

CHAIRMAN

PIERRE CLAUDE NOLIN

DEPUTY CHAIRMAN

COLIN KENNY

SEPTEMBER 2002

TABLE OF CONTENTS

INTRODUCTION 1

PART I - GENERAL ORIENTATION 5

CHAPTER 1 - OUR MANDATE 7
WORDING 7
ORIGINS 9
INTERPRETATION 10

CHAPTER 2 - OUR WORK 13
TWO WORKING PRINCIPLES 14
STATE OF KNOWLEDGE 15
Research Program 18
Expert Witnesses 19
The Challenge of Synthesis 21
TAKING OPINIONS INTO ACCOUNT 22
INTERPRETING IN LIGHT OF PRINCIPLES 23

CHAPTER 3 - OUR GUIDING PRINCIPLES 25
ETHICS, OR THE PRINCIPLE OF RECIPROCAL AUTONOMY 28
GOVERNANCE: MAXIMIZING THE ACTIONS OF INDIVIDUALS 32
Collective governance 34
Governance of the self 35
The role of governance 37
CRIMINAL LAW AND THE LIMITS OF PROHIBITION 38
Requirement for distinctions 38
Criteria for distinction 40
Application to illegal drugs issues 44
SCIENCE OR APPROXIMATE KNOWLEDGE 45
CONCLUSIONS 49

CHAPTER 4 - A CHANGING CONTEXT 51
CHANGES IN THE INTERNATIONAL SPHERE 51
Globalization and Integration 51
Difficulties of the Security Debate 55
From Anti-Drug Policies to Drug Policies 57
CHANGES IN CANADA 58
Judicial Activism 58
A National Crime Prevention Strategy 59
The Fight Against Organized Crime 59
A SOCIETAL DEBATE 60

PART II - CANNABIS: EFFECTS, TYPES OF USE, ATTITUDES 63

CHAPTER 5 - CANNABIS : FROM PLANT TO JOINT 65
ONE PLANT, VARIOUS DRUGS 66
CANNABIS ROADS 69
PROPERTIES OF CANNABIS 77
Δ^9THC Concentrations 78
Pharmacokinetics 83
CONCLUSIONS 87

CHAPTER 6 - USERS AND USES : FORM, PRACTICE, CONTEXT 89
PATTERNS OF USE 90
Consumption by the population as a whole 91
Consumption among young people 94
Use patterns in other countries 101
To summarize 108
PATTERNS AND CIRCUMSTANCES OF USE 111
Cannabis in History 111
Trajectories of Use 113
Factors Related to Use 119
To summarize 124
STEPPING STONE TOWARDS OTHER DRUGS? 125
CANNABIS, VIOLENCE AND CRIME 127
CONCLUSIONS 128

CHAPTER 7 - CANNABIS : EFFECTS AND CONSEQUENCES 131
EFFECTS AND CONSEQUENCES OF CANNABIS: WHAT WE WERE TOLD 134
ACUTE EFFECTS OF CANNABIS 139
CONSEQUENCES OF CHRONIC USE 143
Physiological Consequences of Chronic Use 143
Cognitive and Psychological Consequences 148
Behavioural and Social Consequences 152
TOLERANCE AND DEPENDENCE 152
Cannabis Dependence 154
Severity of Dependence 160
Tolerance 162
To summarize 163
CONCLUSIONS 164

CHAPTER 8 - DRIVING UNDER THE INFLUENCE OF CANNABIS 167
FORMS OF TESTING 170
EPIDEMIOLOGICAL DATA 175
Studies not involving accidents 175
Studies where an accident was involved 176
Epidemiological studies on youth 179

Risk assessment 180
EXPERIMENTAL STUDIES 182
Non-driving activities 183
While driving 184
CONCLUSIONS 188

CHAPTER 9 - USE OF MARIJUANA FOR THERAPEUTIC PURPOSES 191
HISTORY 196
CONTEMPORARY KNOWLEDGE 197
Therapeutic uses 198
Marijuana as a drug? 200
CURRENT THERAPEUTIC PRACTICES 203
CONCLUSIONS 205

CHAPTER 10 - CANADIANS' OPINIONS AND ATTITUDES 209
THE MEDIA 210
SURVEYS 215
ATTITUDES AND OPINIONS SHARED WITH THE COMMITTEE 221
CONCLUSIONS 224

PART III - POLICIES AND PRACTICES IN CANADA 225

CHAPTER 11 - A NATIONAL DRUG STRATEGY? 227
PHASE I - DEVELOPMENT AND IMPLEMENTATION 228
Creation of the Canadian Centre on Substance Abuse 233
Creation of Canada's Drug Strategy Secretariat 236
PHASE II - RENEWAL 237
PHASE III – RENEWAL WITHOUT SPECIFIED FUNDING 240
CANADA'S DRUG STRATEGY – A SUCCESS? 241
CONCLUSIONS 243

CHAPTER 12 - THE NATIONAL LEGISLATIVE CONTEXT 245
1908-1960: HYSTERIA 248
Opium Act, 1908 252
The Opium and Narcotic Drug Act, 1911 253
Amendme nts to the Opium and Narcotic Drug Act (1920-1938) 255
Amendments to the Act to Amend the Opium and Narcotic Drug Act in 1954 263
Senate Report of 1955 264
FROM 1960 TO THE LE DAIN COMMISSION: THE SEARCH FOR REASONS 268
Narcotic Control Act (1961) 268
An Act respecting Food and Drugs and Barbiturates (1961) 270
The Le Dain Commission (1969-1973) 272
Bill S-19 and Cannabis 283
AFTER LE DAIN: FORGING AHEAD REGARDLESS 284
Controlled Drugs and Substances Act 286
CONCLUSIONS 295

CHAPTER 13 - REGULATING THERAPEUTIC USE OF CANNABIS	297
BACKGROUND TO THE RECENT REGULATIONS	298
Section 56 – Controlled Drugs and Substances Act	298
Charter Challenges – Therapeutic Use of Marijuana	299
Government Reaction	302
MARIHUANA MEDICAL ACCESS REGULATIONS	302
Authorization to Possess	303
Licence to Produce	306
Other Provisions	307
COMPASSIONATE ACCESS?	308
Eligibility	309
Access to cannabis	312
Products	316
Costs	316
RESEARCH PLAN	317
Scientific Research	318
Research-Grade Marijuana	320
CONCLUSIONS	321
CHAPTER 14 - POLICE PRACTICES	323
ENFORCEMENT AGENCIES	323
RCMP	323
CHARGES UNDER THE CONTROLLED DRUGS AND SUBSTANCES ACT IN 1999	326
TheCanada Customs and Revenue Agency	326
Provincial and Municipal Police	328
COSTS	328
POLICE POWERS	333
Searches and Seizures	335
Entrapment and Illegal Activity	347
Conclusion	352
STATISTICS	353
Reported Incidents	353
Charges	356
Concerns	359
Customs Act - Fines	361
SEIZURES	362
CONCLUSIONS	364
CHAPTER 15 - THE CRIMINAL JUSTICE SYSTEM	367
PROSECUTION	367
COURTS	368
Drug Treatment Courts	369
DISPOSITION AND SENTENCING	372
CORRECTIONS	376
CRIMINAL RECORD	379
COURT CHALLENGES	382
CONCLUSIONS	387

CHAPTER 16 - PREVENTION 389
INITIATIVES THAT FALL SHORT OF THE MARK 393
Not enough prevention 394
Prevention lacks focus 396
There is not enough evaluation of preventive measures 397
Preventive and social messages in contradiction 398
There is a body of knowledge on which we have to draw 399
PREVENTING WHAT AND HOW? 400
RISK REDUCTION AND HARM REDUCTION 410
CONCLUSIONS 412

CHAPTER 17 - TREATMENT PRACTICES 415
CANNABIS DEPENDENCY 415
FORMS OF TREATMENT 421
EFFECTIVENESS OF TREATMENT 423
CONCLUSIONS 426

CHAPTER 18 - OBSERVATIONS ON PRACTICES 427
DIFFICULTIES IN HARMONIZING THE PLAYERS 427
INCONGRUITIES OF APPROACH 429
SIGNIFICANT ECONOMIC AND SOCIAL COSTS 431

PART IV - PUBLIC POLICY OPTIONS 437

CHAPTER 19 - THE INTERNATIONAL LEGAL ENVIRONMENT 439
A GENEALOGY 440
The 1909 Shanghai Conference 443
The 1912 Hague International Opium Convention 444
The 1925 Geneva Opium Conventions 446
The 1931 Geneva Narcotics Manufacturing and Distribution Limitation Convention / 1931 Bangkok Opium Smoking Agreement 447
The 1936 Geneva Convention for the Suppression of the Illicit Traffic in Dangerous Drugs 448
The Second World War 449
The 1946 Lake Success Protocol 449
The 1948 Paris Protocol 450
The 1953 New York Opium Protocol 450
THE THREE CURRENT CONVENTIONS 451
The Single Convention on Narcotic Drugs, 1961 451
Convention on Psychotropic Substances 455
Protocol amending the Single Convention on Narcotic Drugs, 1961 460
Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 462
SOME LEEWAY? 464
CONCLUSIONS 468

CHAPTER 20 - PUBLIC POLICIES IN OTHER COUNTRIES **469**
FRANCE 470
Different Forms of Logic 470
An Integrated Public Policy 472
Legislative Framework 474
Key Reports 477
Statistics on Use and Offences 481
Costs 483
THE NETHERLANDS 485
Dutch Pragmatism? 486
Essential Experts Reports 488
Legislation 493
The Coffee Shop System 496
Data on Use 498
UNITED KINGDOM 502
Ten-Year Strategy to Battle Drugs 502
Legislative Framework 503
Other Relevant Legislation in the Field of Drug Misuse 505
Debate in the UK 506
Recent Key Reports and Studies 507
Administration 515
Costs 515
Statistics 516
SWEDEN 518
National Strategy 520
Legislative Framework 523
Debate in Sweden 525
Recent Reports 526
Costs 528
Administration 528
Statistics 529
SWITZERLAND 531
A Harm Reduction Policy 531
The Legal Framework 538
A Bill to Decriminalize Cannabis 539
Administration of Swiss Drug Policy 542
Statistics on Narcotics Use and Offences under the Narcotics Act 544
AUSTRALIA 546
National Drug Strategy 546
Legislative Framework 551
Decriminilization in Australia 554
Administration 556
Statistics 557
UNITED STATES 560
The Federal-State Legislative Framework 560
Current Legislation and Enforcement 563
Federal Drug Policy Goals and Objectives 570
Administration of the Policy 572
Current Issues and Debates 575

Statistics 576

CHAPTER 21 - PUBLIC POLICY OPTIONS **581**
INEFFECTIVENESS OF CRIMINAL POLICIES 583
Impact on Consumption 583
Impact on Supply 589
Conclusion 590
GENERAL ECONOMY OF A PUBLIC POLICY ON CANNABIS 591
COMPONENTS OF A PUBLIC POLICY 593
Strong Decision-making Body 593
Interconnection 594
A Shared Definition of Shared Objectives 594
Information Tools 594
LEGISLATIVE OPTIONS 595
Clarification of criminology 595
Criteria for a Legal Policy on Cannabis 602

CONCLUSIONS AND RECOMMENDATIONS **607**

LE DAIN – ALREADY THIRTY YEARS AGO 607
INEFFECTIVENESS OF THE CURRENT APPROACH 609
PUBLIC POLICY BASED ON GUIDING PRINCIPLES 610
A CLEAR AND COHERENT FEDERAL STRATEGY 611
NATIONAL STRATEGY SUSTAINED BY ADEQUATE RESOURCES AND TOOLS 612
A PUBLIC HEALTH POLICY 614
A REGULATORY APPROACH TO CANNABIS 617
A COMPASSION-BASED APPROACH FOR THERAPEUTIC USE 618
PROVISIONS FOR OPERATING A VEHICLE UNDER THE INFLUENCE OF CANNABIS 619
RESEARCH 620
CANADA'S INTERNATIONAL POSITION 621

PROPOSALS FOR IMPLEMENTING THE REGULATION OF CANNABIS FOR THERAPEUTIC AND RECREATIONAL PURPOSES **623**

BIBLIOGRAPHY **627**

GLOSSARY OF KEY TERMS

Abuse

Vague term with a variety of meanings depending on the social, medical and legal contexts. Some equate any use of illicit drugs to abuse: for example, the international conventions consider that any use of drugs other than for medical or scientific purposes is abuse. The Diagnosis and Statistical Manual of the American Psychiatric Association defines abuse as a maladaptive pattern of substance use leading to clinically significant impairment or distress as defined by one or more of four criteria (see chapter 7). In the report, we prefer the term excessive use (or harmful use).

Acute effects

Refers to effects resulting from the administration of any drug and specifically to its short term effects. These effects are distinguished between central (cerebral functions) and peripheral (nervous system). Effects are dose-related.

Addiction

General term referring to the concepts of tolerance and dependency. According to WHO addiction is the repeated use of a psychoactive substance to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance, has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain the substance by almost any means. Some authors prefer the term addiction to dependence, because the former also refers to the evolutive process preceding dependence. (toxicomanie a de l'information additionelle)

Agonist

A substance that acts on receptor sites to produce certain responses.

Anandamide

Agonist neurotransmitter of the endogenous cannabinoid system. Although not yet fully understood in research, these neurotransmitters seem to act as modulators, THC increasing the liberation of dopamine in nucleus accumbens and cerebral cortex.

At-risk use

Use behaviour which makes users at-risk of developing dependence to the substance.

Cannabinoids

Endogenous receptors of the active cannabis molecules, particularly 9-THC. Two endogenous receptors have been identified: CB1 densely concentrated in the hippacampus, basal ganglia, cerebellum and cerebral cortex, and CB2, particularly abundant in the immune system. The central effects of cannabis appear to be related only to CB1.

Cannabis

Three varieties of the cannabis plant exist: *cannabis sativa*, *cannabis indica*, and *cannabis ruredalis*. *Cannabis sativa* is the most commonly found, growing in almost any soil condition. The cannabis plant has been known in China for about 6000 years. The flowering tops and leaves are used to produce the smoked cannabis. Common terms used to refer to cannabis are pot, marihuana, dope, ganja, hemp. Hashish is produced from the extracted resin. Classified as a psychotropic

drug, cannabis is a modulator of the central nervous system. It contains over 460 known chemicals, of which 60 are cannabinoids. Delta-9-tétrahydrocannabinol, referred to as THC, is the principal active ingredient of cannabis. Other components such delta-8-tétrahydrocannabinol, cannabinol and cannabidiol are present in smaller quantities and have no significant impacts on behaviour or perception. However, they may modulate the overall effects of the substance.

Chronic effects
Refers to effects which are delayed or develop after repeated use. In the report we prefer to use the term consequences of repeated use rather than chronic effects.

Commission on narcotic drugs (CND)
The Commission on Narcotic Drugs (CND) was established in 1946 by the Economic and Social Council of the United Nations. It is the central policy-making body within the UN system for dealing with all drug-related matters. The Commission analyses the world drug abuse situation and develops proposals to strengthen international drug control.

Decriminalization
Removal of a behaviour or activity from the scope of the criminal justice system. A distinction is usually made between *de jure decriminalization*, which entails an amendment to criminal legislation, and *de facto decriminalization*, which involves an administrative decision not to prosecute acts that nonetheless remain against the law. Decriminalization concerns only criminal legislation, and does not mean that the legal system has no further jurisdiction of any kind in this regard: other, non-criminal, laws may regulate the behaviour or activity that has been decriminalized (civil or regulatory offences, etc.).

Diversion
The use of measures other than prosecution or a criminal conviction for an act that nonetheless remains against the law. Diversion can take place before a charge is formally laid, for example if the accused person agrees to undergo treatment. It can also occur at the time of sentencing, when community service or treatment may be imposed rather than incarceration.

Depenalisation
Modification of the sentences provided in criminal legislation for a particular behaviour In the case of cannabis, it generally refers to the removal of custodial sentences.

Dependence
State where the user continues its use of the substance despite significant health, psychological, relational, familial or social problems. Dependence is a complex phenomenon which may have genetic components. Psychological dependence refers to the psychological symptoms associated with craving and physical dependence to tolerance and the adaptation of the organism to chronic use. The American Psychiatric Association has proposed seven criteria (see chapter 7).

Dopamine
Neuromediator involved in the mechanisms of pleasure.

Drug
Generally used to refer to illicit rather than licit substances (such as nicotine, alcohol or medicines). In pharmacology, the term refers to any chemical agent that alters the biochemical

or physiological processes of tissues or organisms. In this sense, the term drug refers better to any substance which is principally used for its psychoactive effects.

European Monitoring Centre on Drugs and Drug Addiction (EMCDDA)
The European Monitoring Centre was created in 1993 to provide member states objective, reliable and comparable information within the EU on drugs, drug addictions and their consequences. Statistical information, documents and techniques developed in the EMCDDA are designed to give a broad perspective on drug issues in Europe. The Centre only deals with information. It relies on national focal points in each of the Member States.

Fat soluble
Characteristic of a substance to irrigate quickly the tissues. THC is highly fat-soluble.

Gateway (theory)
Theory suggesting a sequential pattern in involvement in drug use from nicotine to alcohol, to cannabis and then "hard" drugs. The theory rests on a statistical association between the use of hard drugs and the fact that these users have generally used cannabis as their first illicit drug. This theory has not been validated by empirical research and is considered outdated.

Half-life
Time needed for the concentration of a particular drug in blood to decline to half its maximum level. The half-life of THC is 4.3 days on average but is faster in regular than in occasional users. Because it is highly fat soluble, THC is stored in fatty tissues, thus increasing its half life to as much as 7 to 12 days. Prolonged use of cannabis increases the period of time needed to eliminate is from the system. Even one week after use, THC metabolites may remain in the system. They are gradually metabolised in the urine (one third) and in feces (two thirds). Traces on inactive THC metabolites can be detected as many as 30 days after use.

Hashish
Resinous extract from the flowering tops of the cannabis plant and transformed into a paste.

International Conventions
Various international conventions have been adopted by the international community since 1912, first under the Society of Nations and then under the United Nations, to regulate the possession, use, production, distribution, sale, etc., of various psychotropic substances. Currently, the three main conventions are the 1961 Single Convention, the 1971 Convention on Psychotropic Substance and the 1988 Convention against Illicit Traffic. Canada is a signatory to all three conventions. Subject to countries' national constitutions, these conventions establish a system of regulation where only medical and scientific uses are permitted. This system is based on the prohibition of source plants (coca, opium and cannabis) and the regulation of synthetic chemicals produced by pharmaceutical companies.

International Narcotics Control Board (INCB)
The Board is an independent, quasi-judicial organisation responsible for monitoring the implementation of the UN conventions on drugs. It was created in 1968 as a follow up to the 1961 Single Convention, but had predecessors as early as the 1930s. The Board makes recommendations to the UN Commission on Narcotics with respect to additions or deletions in the appendices of the conventions.

Intoxication
Disturbance of the physiological and psychological systems resulting from a substance. Pharmacology generally distinguishes four levels: light, moderate, serious and fatal.

Joint
Cigarette of marijuana or hashish with or without tobacco. Because joints are never identical, scientific analyses of the effects of THC are more difficult, especially in trying to determine the therapeutic benefits of cannabis and to examine its effects on driving.

Legalisation
Regulatory system allowing the culture, production, marketing, sale and use of substances. Although none currently exist in relation to « street-drugs » (as opposed to alcohol or tobacco which are regulated products), a legalisation system could take two forms: without any state control (free markets) and with state controls (regulatory regime).

Marijuana
Mexican term originally referring to a cigarette of poor quality. Has now become equivalent for cannabis.

Narcotic
Substance which can induce stupor or artificial sleep. Usually restricted to designate opiates. Sometimes used incorrectly to refer to all drugs capable of inducing dependence.

Office of national drug control policy (ONDCP) USA
Created in 1984 under the Reagan presidency, the Office is under the direct authority of the White House. It coordinates US policy on drugs. Its budget is currently US $18 billion.

Opiates
Substance derived from the opium poppy. The term opiate excludes synthetic opioids such as heroin and methadone.

Prohibition
Historically, the term designates the period of national interdiction of alcohol sales in the United States between 1919 and 1933. By analogy, the term is now used to describe UN and State policies aiming for a drug-free society. Prohibition is based on the interdiction to cultivate, produce, fabricate, sell, possess, use, etc., some substances except for medical and scientific purposes.

Psychoactive substance
Substance which alters mental processes such as thinking or emotions. More neutral than the term "drug" because it does not refer to the legal status of the substance, it is the term we prefer to use.

Psychotropic substance (see also psychoactive)
Much the same as psychoactive substance. More specifically however, the term refers to drugs primarily used in the treatment of mental disorders, such as anxiolytic, sedatives, neuroleptics, etc. More specifically, refers to the substances covered in the 1971 Convention on Psychotropic Substances.

Regulation
Control system specifying the conditions under which the cultivation, production, marketing, prescription, sales, possession or use of a substance are allowed. Regulatory approaches may rest on interdiction (as for illegal drugs) or controlled access (as for medical drugs or alcohol). Our proposal of an exemption regime under the current legislation is a regulatory regime.

Society of Nations (SDN)
International organisation of States until 1938; now the United Nations.

Tetrahydrocannabinol (Δ9-THC)
Main active component of cannabis, Δ9-THC is very fat-soluble and has a lengthy half-life. Its psychoactive effects are modulated by other active components in cannabis. In its natural state, cannabis contains between 0.5% to 5% THC. Sophisticated cultivation methods and plant selection, especially female plants, leads to higher levels of THC concentration.

Tolerance
Reduced response of the organisms and increased capacity to support its effects after a more or less lengthy period of use. Tolerance levels are extremely variable between substances, and tolerance to cannabis is believed to be lower than for most other drugs, including tobacco and alcohol.

Toxicity
Characteristic of a substance which induces intoxication, i.e., "poisoning". Many substances, including some common foods, have some level of toxicity. Cannabis presents almost no toxicity and cannot lead to an overdose.

United Nations Drug Control Program (UNDCP)
Established in 1991, the Programme works to educate the world about the dangers of drug abuse. The Programme aims to strengthen international action against drug production, trafficking and drug-related crime through alternative development projects, crop monitoring and anti-money laundering programmes. UNDCP also provides accurate statistics through the Global Assessment Programme (GAP) and helps to draft legislation and train judicial officials as part of its Legal Assistance Programme. UNDCP is part of the UN Office for Drug Control and the Prevention of Crime.

World Health Organization (WHO)
The World Health Organization, the United Nations specialized agency for health, was established on 7 April 1948. WHO's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health. Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

PART III

POLICIES AND PRACTICES IN CANADA

CHAPTER 11

A NATIONAL DRUG STRATEGY?

There is no arguing that both licit and illicit psychoactive substances affect Canadians in many ways, both positively and negatively, both directly and indirectly. In addition, no one would dispute the fact that psychoactive substance use (again, both licit and illicit) is a widespread phenomenon, not only on the part of adults but also among the youths of this country. Because of the potential problems for those who abuse psychoactive substances, dealing with this issue should be a matter of serious concern for any government, and for society as a whole.

Based on the importance of the subject, it would probably surprise many Canadians to learn that only from 1987 to 1993 did Canada have a fully funded national drug strategy. It is true that Canada has had legislation dealing with the use of psychoactive substances since the passage of the *Opium Act* in 1908. This Act was followed by several pieces of criminal legislation over the years that increased federal enforcement powers over psychoactive substances and expanded the list of illicit substances.[1] These pieces of legislation have historically focused on the supply of psychoactive substances, adopting a prohibitionist approach to use. It is widely acknowledged, however, that a more balanced approach is required if one is to deal effectively with those who abuse psychoactive substances.

This chapter will recount the development and implementation of the 1987 National Drug Strategy, which had as an objective the promotion of a balanced approach to the problem of psychoactive substance abuse. This will be followed by a discussion of what became of the national strategy and whether its goals have been achieved.

---

[1] A discussion of Canada's legislative history in regard to psychoactive substances can be found in Chapter 12.

PHASE I - DEVELOPMENT AND IMPLEMENTATION

In May 1987, the federal government announced a $210-million, five-year action plan to curb drug abuse. The government stated that the action plan was in response to mounting concerns regarding increasing rates of drug-related problems. Others have suggested that *"(t)his strong political action was undoubtedly influenced by the latest American 'War on Drugs.'"*[2]

The National Drug Strategy (NDS), *Action on Drug Abuse*, was launched by the then Minister of National Health and Welfare, who was the lead Minister in the federal effort to curb drug abuse.[3] Several other departments also participated in the first interdepartmental attempt to co-ordinate Canada's response to its drug abuse problem. It was believed that there was a need for a coordinated, strategic approach to the problem of drug abuse in Canada. The overall objective of the NDS was *"to reduce the harm to individuals, family and communities from the abuse of alcohol and other drugs through a balanced approach that is acceptable to Canadians."*[4] Other partners included provincial and municipal governments, business, law enforcement agencies, and professional and voluntary organizations.

The federal government recognized that, in the past, the emphasis of its involvement in this area had been largely restricted to supply control measures. Meanwhile, communities, provinces and territories, and many professional and volunteer groups, had focused their efforts on reducing the demand for drugs, through prevention and treatment programs. Given the division of constitutional powers in Canada, this separation of responsibilities is not altogether surprising. It does, however, impose limits on the establishment of a comprehensive national framework.

> *The division of powers between Canadian provinces and the federal government has made concerted, comprehensive action against drug and alcohol abuse very difficult to achieve. For example, most program strategies aimed at prevention are generally seen as part of the health or education systems; matters of provincial jurisdiction over which the federal government has little direct control. However, while enforcement activities are controlled at the local level, for the most part, the authority derives from federal powers, and the control largely remains with the federal government.*[5]

In developing the NDS, the federal government noted that, within the provinces and territories, and at the community level, many innovative programs of drug counselling, therapy and rehabilitation had been initiated. It also recognized that much

---

[2] Giffen, P.J., Endicott, S. and S. Lambert, (1991) *Panic and Indifference: The Politics of Canada's Drug Laws*, Ottawa: Canadian Centre on Substance Abuse, page 587.

[3] Government of Canada, News Release, *Federal Government Launches Co-ordinated Action on Drug Abuse*, 25 May 1987.

[4] Government of Canada, *Action on Drug Abuse: Making a Difference*, 1988, page 5.

[5] Giffen, P.J., *op. cit.*, page 585.

of the program expertise existed at the provincial level. What was lacking, however, was a strong mechanism for national collaboration. The government believed that the NDS provided such a comprehensive national framework and viewed it as *"a co-operative program that combines the efforts and resources of the federal government with those of all provincial and territorial governments and addiction agencies across Canada."*[6]

The government identified six core components of the NDS: education and prevention; enforcement and control; treatment; international cooperation; research and information; and national focus. Of the $210 million in new federal funds allocated to enhance existing programs and to fund new initiatives, $20 million was allocated for the first year, $40 million for the second year, and $50 million for the last three years of the strategy. A significant amount (70%) of the resources was committed to education and prevention (32%) and treatment and rehabilitation (38%); 20% was committed to enforcement and control; and the other 10% to information and research (6%), international co-operation (3%) and national focus (1%).[7] The government noted that, while enforcement agencies were given more resources to combat supply, most of the money was allocated to address the demand for psychoactive substances, thus providing a better balance between reducing both the demand for drugs and reducing their supply.[8] According to information received from Health Canada, the resources were generally spent as planned.

In order to illustrate the comprehensive nature of the NDS, the following sets out the goals and initiatives announced during the week of its launch:

Prevention, treatment, research, control components[9]

- To create improved public awareness and information:
  - A media campaign, developed in consultation with provinces;
  - Federal endorsement of Drug Awareness Week;
  - Telephone information lines.

- To encourage involvement in prevention activities:
  - Support for a range of prevention initiatives developed within local communities;
  - Support for the development of innovative and improved treatment services at the community level;

---

[6] Government of Canada, *Action on Drug Abuse: Making a Difference*, 1988, page 7.

[7] *Ibid.*

[8] From 1987 to 1991, an additional $19.5 million was provided for the Driving While Impaired (DWI) Strategy. The DWI strategy included national awareness programs, driver education curricula, national surveys and hundreds of local initiatives aimed at making drinking and driving socially unacceptable to Canadians.

[9] Government of Canada, *National Drug Strategy: Prevention, Treatment, Research, Control Components*, 25 May, 1987.

- Development and expansion of training and training materials;
- A National Action Conference on Drug Abuse.

❖ To encourage prevention initiatives targeted to particular groups:

- Efforts to encourage youth employment activities that improve life-skills development as well as employability;
- Support for demonstration projects by police to develop new prevention initiatives for youth in school, and for urban youth at risk and Aboriginal communities;
- A review of all current programming directed at drug abuse among Aboriginal people;
- New initiatives focussed particularly at Aboriginal youth;
- Support for northern communities wishing to exchange experiences with other Arctic Rim communities on drug abuse issues.

❖ To encourage more effective treatment services tailored to specific needs:

- An examination of future federal cost-sharing of new or expanded drug and alcohol treatment and rehabilitation programs;
- Measures to improve detection of drug abuse by health professionals and to support their rehabilitation;
- Establishment of an advisory committee on methadone and measures to prevent diversion of methadone;
- Development of training materials and information for health care professionals and others working in the addictions field;
- A review of current efforts to address the problem of drugs in the workplace;
- Continued efforts to eliminate the use of banned drugs in sport within Canada and internationally.

❖ To update and improve Canada's drug laws and regulations:

- New legislation to replace the outdated *Narcotics Control Act* and *Food and Drugs Act*;
- Improved co-ordination among federal organizations and with provinces to improve regulatory control of drug use;
- Increased federal capacity for drug identification, analysis and monitoring;
- Co-ordinated policies concerning illegal supply of drugs in Canada.

❖ To improve the knowledge base in the drug abuse field:

- Support research on patterns and trends in the drug abuse field and on prevention and treatment;
- A study and recommendations on priority data needs.

❖ To ensure a long-term commitment to the drug abuse field where long-term solutions are needed:

- A Task Force to review different means of ensuring that provincial expertise and experience can be made available for the benefit of the country as a whole and to ensure national ongoing commitment to promoting the study and prevention of drug abuse.

Enforcement components[10]

❖ To provide strengthened and co-ordinated drug law enforcement:

- Strengthening of the RCMP's drug intelligence capabilities and liaison with other forces;
- A co-ordinated approach to improved coastal enforcement against drug smuggling;
- Improved co-ordination of drug law enforcement at the federal level as well as between federal and provincial organizations.

❖ To help take the profit out of illegal drug trafficking:

- Expansion of the RCMP's Anti-Drug Profiteering Program and improved public awareness of program activities and objectives;
- Improved techniques for tracing illicit funds will be developed.

❖ To strengthen Canada's international efforts:

- RCMP special training in drug enforcement for police officers of selected drug source or transit countries.

❖ To create improved public awareness and information about drug abuse:

- An expansion in the RCMP's capacity across the country to promote drug awareness.

❖ To address the problems of drug abuse in federal correctional institutions:

- A study will be undertaken on drug use among inmates and on the effectiveness of current treatment programs in correctional institutions;
- Improved drug control in penitentiaries;

---

[10] Government of Canada, *National Drug Strategy: Enforcement Components*, 26 May 1987.

- Development of programs for inmates with drug abuse problems to help them cope better after their release;
- Improved prevention through training for staff and development of information programs for inmates.

Interdiction components[11]

❖ To strengthen Canada Customs' capacity to interdict illegal drugs entering Canada:

- Expansion of Canada Customs resources to strengthen capability in the critical areas of targeting and examination of high-risk cargo shipments and travellers in all modes of transportation, and of high-risk mail;
- Development and acquisition of X-ray equipment to increase drug detection capabilities during the examination of cargo, baggage and mail;
- Expansion of the Canada Customs Detector Dog Service to provide service in all Customs regions across Canada, and increase our present capabilities at high-volume points of entry;
- Enhanced training to Customs Inspectors in the identification of drug couriers and high-risk commercial shipments: this training will increase the awareness of Customs Inspectors relating to the identification of indicators (characteristics) that may be present during the examination of a person or commercial shipment;
- Expansion of Canada Customs involvement in the Crime Stoppers programs of municipal police forces across Canada;
- Co-operation with airlines and shipping companies engaged in the international transport of people and goods, with a view to Canada Customs obtaining assistance in the detection of illicit drugs destined for Canada;
- Co-operation with foreign Customs services in targeting in-transit drug couriers.

❖ To ensure appropriate immigration policies:

- Review of immigration policy on drug traffickers.

International components[12]

❖ To ensure that Canada plays an active role in international forums on drug abuse:

---

[11] Government of Canada, *National Drug Strategy: Interdiction Components*, 27 May 1987.
[12] Government of Canada, *National Drug Strategy: International Components*, 28 May 1987.

- Canada's active participation at the International Conference on Drug Abuse and Illicit Trafficking to be held in Vienna, 17-26 June 1987;
- Accession to the 1971 United Nations Convention on Psychotropic Substances;
- Increase in Canada's contribution to the United Nations Fund for Drug Abuse Control (UNFDAC) to a target level of $1 million by 1991;
- Inclusion of reduction of drug abuse as a factor in considering requests for assistance under Official Development Assistance;
- Hosting of an international conference of experts on Recommended Methods for Testing Drugs of Abuse.

❖ To improve public awareness and information:
- Information for Canadians travelling abroad about the hazards of illicit drug possession in other countries.

Proceeds of crime components[13]

❖ To take the profit out of illicit drug trafficking:
- Proceeds of Crime legislation to reduce the profitability of drug trafficking.

Creation of the Canadian Centre on Substance Abuse

The Canadian Centre on Substance Abuse (CCSA) was created by an act of Parliament in 1988. It is a non-governmental organization with the aim to promote "*increased awareness on the part of Canadians of matters relating to alcohol and drug abuse and their increased participation in the reduction of harm associated with such abuse, and to promote the use and effectiveness of programs of excellence that are relevant to alcohol and drug abuse.*"[14] This is to be done by:

❖ Promoting and supporting consultation and co-operation among governments, the business community and labour, professional and voluntary organizations in matters relating to alcohol and drug abuse;
❖ Contributing to the effective exchange of information on alcohol and drug abuse;
❖ Facilitating and contributing to the development and application of knowledge and expertise in the alcohol and drug abuse field;
❖ Promoting and assisting in the development of realistic and effective policies and programs aimed at reducing the harm associated with alcohol and drug abuse; and

---

[13] Government of Canada, *National Drug Strategy: Proceeds of Crime Components*, 29 May 1987.
[14] *Canadian Centre on Substance Abuse Act*, R.S., 1985, c. 49 (4th Supp.), s. 3.

awareness of Canadians of addictions issues, and influencing and informing CCSA's key target audiences.

- Network Development
  - Goal 5: To develop, co-ordinate and support networks that facilitate the sharing and application of information and expertise.
- Information and Reference Service
  - Goal 6: To maintain an efficient and responsive information and reference service.
- Administration/Management
  - Goal 7: To organize the policy, administrative and human resource functions in an effective and financially responsible manner.[18]

An important contribution of the CCSA is the establishment of a Clearinghouse on Substance Abuse, which links all major sources of information on alcohol and other drugs in a single computer network.

The CCSA, which is within the portfolio of the Minister of Health, is structured as a corporation, with a chair and a board of directors. It is funded by the NDS and through its own revenue-generating efforts. The CCSA was originally allocated an annual $2 million of core funding but the cuts that occurred as a result of Program Review in 1997 reduced its core funding to $500 000. This necessitated the release of almost all full-time staff. Michel Perron, the CCSA's chief executive officer, indicated that the budget cuts affected the CCSA's ability to carry out its mandate.

> *Since 1997, the CCSA has basically survived by working for a number of departments on contract. Those contracts ensured our survival, but significantly hindered our efforts to fulfill our legal mandate in a proactive way.*[19]

In early 2002, the government increased the CCSA's core funding to $1.5 million. We were told that, with this increase, the CCSA can stabilize its activities and Canada runs a lower risk of losing its only collective memory as well as the only drug addiction specialists working at the federal level.[20]

---

[18] For more information or the CCSA, visit its website at http://www.ccsa.ca and see Government of Canada, *Canada's Drug Strategy - Phase II: A situation paper*, Canada, 1994, pages 38-40.

[19] Michel Perron, Executive Director, Canadian Centre on Substance Abuse, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament 2001-2002, 10 June 2002, Issue no. 22, page 69.

[20] *Ibid.*,

Creation of Canada's Drug Strategy Secretariat

In 1990, Canada's Drug Strategy Secretariat was given the mandate to coordinate activities within the federal government and with other governments (both nationally and internationally). The secretariat was given many responsibilities, including ensuring the visibility of the NDS, coordinating the evaluation of the NDS and examining the issue of substance abuse from a strategic standpoint. One of its key responsibilities was to act as a facilitator.

> *An important function of the Secretariat is to serve as an information source, a central point of entry to the federal government directing those with questions toward people with the answers. Members of the Secretariat also provide advice from outside groups to the federal partners. They attempt to bring groups together to facilitate issues of common concern.*[21]

The Secretariat was disbanded in 1996 during Phase II of the strategy. In the evaluation of Phase II of the CDS, it was suggested that the function of overseeing the coordination should be given to a body that is not an integral part of one of the partner departments–otherwise, such a body would be in a potential or perceived conflict of interest.[22] In the past, some had regarded the Secretariat as representing primarily the interest of Health Canada rather than representing the drug strategy itself.

Today, the Office of Canada's Drug Strategy is the focal point within the federal government for the drug strategy. It describes itself as follows:

> *The Office of Canada's Drug Strategy of Health Canada is the focal point within the federal government for harm reduction, prevention, and treatment and rehabilitation initiatives concerning alcohol and other drugs issues. Our efforts aim to prevent the use of drugs by those not currently using them, reduce the harm for those who use them, and promote effective and innovative treatment and rehabilitation for those affected by substance abuse. The Office works collaboratively with other federal departments and provincial and territorial governments, and provides national leadership and co-ordination on substance abuse issues, conducts research into the risk factors and root causes of substance abuse, synthesizes and disseminates leading-edge information and best practices to key partners, and collaborates with multilateral organizations to address the global drug problem.*[23]

The Auditor General, in her 2001 Report, indicated that there are limits on Health Canada's authority as coordinator and recommended that the government *"review the current mechanisms for leadership and co-ordination within the federal government as well as mechanisms for co-ordination with provincial/territorial and municipal governments in addressing the problem of illicit drugs."*[24] We agree with the Auditor General's assessment and recommend

---

[21] Government of Canada, *Canada's Drug Strategy - Phase II: A situation paper*, Canada, 1994, pages 11-12.
[22] Health Canada, *Evaluation of Canada's Drug Strategy: Final Report*, June 1997, page 22.
[23] Information regarding the Office of Canada's Drug Strategy can be found on the Health Canada web site at http://www.hc-sc.gc.ca/hppb/cds-sca/cds/about.html (revised: 1 December 2000).
[24] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 24.

the creation of a position of National Drug Advisor, responsible for ensuring interdepartmental co-ordination at the federal level. In addition, the CCSA would be given a coordinating role with respect to the provinces and territories, cities and with research bodies and universities.

PHASE II - RENEWAL

In order to determine the future of the NDS, the federal government undertook a national consultation process in March and April 1991. The purpose of the consultations, held with local and provincial partners, was to prepare for the possible renewal of the NDS, obtain information on the strengths and weaknesses of the strategy and identify renewal priorities. During the consultations, alcohol abuse was identified as the major problem in Canada, and the abuse and misuse of pharmaceuticals was the second most frequently mentioned concern. Tobacco use was also seen as a major substance abuse and health problem. Street drugs, while still a concern, were not a major worry of those consulted. It was noted that cannabis use continued to be widespread.

Many at the consultations advocated incorporating the Driving While Impaired (DWI) Strategy into the NDS, and there was also strong support for a comprehensive national alcohol policy. It was also suggested that use of steroids by athletes and youth be included in the NDS. Finally, others called for a comprehensive tobacco policy and for tobacco's inclusion within the NDS. A long-term commitment to the drug strategy was one of the issues stressed by the participants.

> *To address many problems in substance abuse, participants in the consultation process stressed the need for a long-term commitment to CDS. Substance abuse has been a problem since the dawn of time. To expect significant changes in the level and nature of substance abuse over a five, or even a ten, year period is not realistic. The impact of initiatives to counteract the problem of substance abuse may not be visible for generations. Therefore, CDS must become an ongoing program with political and government support and endorsement. Bringing about fundamental long-term societal changes in attitude and behaviour requires base funding, without a sunset provision.*[25]

In 1992, the NDS was renewed under the designation Canada's Drug Strategy (CDS). Funding was increased to $270 million over the five-year period and the Strategy principally involved six federal departments.[26] As had been suggested, the DWI Strategy became a component of CDS, although the same could not be said for

---

[25] Government of Canada, *Canada's Drug Strategy: Consultations 1991*, page 7. For more information on comments made regarding supply issues, demand issues and the role and impact of CDS, see pages 3-7.

[26] Health and Welfare Canada, Solicitor General Canada, Revenue Canada (Customs and Excise), Labour Canada, External Affairs and International Trade Canada and Justice Canada.

tobacco. Once again, CDS called for a balanced approach to reducing both the demand for drugs and their supply. The funding was to be allocated as follows: prevention (30%); treatment (30%); enforcement and control (28%); information and research (5%); national focus (5%); and international co-operation (1%). According to Health Canada, over the five-year period, about $104.4 million was actually provided.[27] In fact, resources that were originally approved were almost immediately reduced, and this reduction continued over the course of CDS as a result of budget cuts.

In renewing CDS, the federal government acknowledged the concerns of stakeholders and stated that solutions to substance abuse require long-term commitment–that to expect significant changes over five or even ten years was not realistic. Thus, it was stated that CDS should become an ongoing program. In addition, it was thought that a balanced approach between demand and supply reduction was critical to the success of CDS. Finally, it was recognized that partnerships (both governmental and non-governmental) at all levels (locally, nationally and internationally) were needed.[28]

On the whole, it was concluded that the strategy was working well and that it was important to maintain the momentum created by Phase I. The primary and overall objective of Phase II was to make Canada's alcohol and other drug interventions more effective at reducing harm to individuals, families, and communities caused by the problem use of alcohol and other drugs. This would be accomplished through the following secondary objectives:

- Improved program targeting through a focus on high-risk populations (especially young children, street kids, dropouts, off-reserve Aboriginals, the unemployed, seniors and women);
- Improved coordination and collaboration across federal departments and with external partners (provincial and territorial governments, non-governmental organizations, etc.);
- An improved information base on substance abuse-related issues, to assist policy-makers, program developers, researchers, professionals, and others concerned with substance abuse issues in addressing this problem; and
- Enhanced resources that would enable departments to continue certain ongoing activities and redirect attention to emerging issues or new activities.[29]

The decision to renew CDS was accompanied by a requirement for its evaluation. In June 1997 a report evaluating Phase II of CDS was published by Health Canada. Its main findings were as follows:

---

[27] Gillian Lynch, Director General, Drug Strategy and Controlled Substances Programme, Health Canada, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament 2001-2002, 10 June 2002, Issue no. 22, page 27.

[28] Government of Canada, *Canada's Drug Strategy – Phase II*, 1992, page 3.

[29] Health Canada, *Evaluation of Canada's Drug Strategy: Final Report*, June 1997, p. iv.

- Improved program targeting was implemented in all participating departments, with justifiable variation according to their respective mandates;
- Interdepartmental coordination at the working level and for task-specific initiatives was effective. However, interdepartmental co-ordination at the strategic planning level was identified as a concern over the course of Phase II and would not appear to have been resolved (clear coordination goals were not identified, nor was the role of the CDS Secretariat properly defined);
- CDS did not have national visibility at either political or public levels;
- The information available in Canada on the issue of substance abuse increased as a result of Phase II funding;
- Departmental resources were increased through Phase II. However, there were significant subsequent cuts to some departmental budgets that may have limited the potential achievements of Phase II; and
- Phase II resources were used in a manner consistent with a harm reduction approach, although a formal harm reduction policy was not in place during the course of the strategy.

The report also identified effective leadership, coordination and strategic planning as essential to the strategy, and found weaknesses in these areas during Phase II. In addition, a common vision and a set of clear and measurable objectives were also found to be fundamental requisites. Lack of accountability for strategy-wide objectives was also identified as a problem. As will be discussed later, most of these issues were again raised as concerns in 2001 (five years later) by the Auditor General of Canada

To coordinate the strategy, two groups were established at the federal level, both chaired by Health Canada: the Assistant Deputy Ministers' Steering Committee on Substance Abuse, and the Interdepartmental Working Group on Substance Abuse. Their purpose has been described as follows:

> *The Steering Committee is mandated to meet at least twice a year to improve the overall effectiveness of the strategy and provide direction to the Working Group. Its aims are to co-ordinate federal activities, develop consensus on priorities, address emerging issues, and monitor implementation of the federal strategy.* [30]

PHASE III – RENEWAL WITHOUT SPECIFIED FUNDING

In 1997, the *Controlled Drugs and Substances Act* (CDSA) was enacted. This legislation formed part of CDS; it was focused, according to the government, on

[30] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 6.

modernizing and enhancing the drug abuse control policy underlying the previous legislation and on fulfilling Canada's international obligations. It should be noted that since the introduction of the CDSA, most changes to federal legislation dealing with illicit drugs have focused on supply reduction.

In 1998, CDS was renewed in principle but without any specified funding, despite warnings of possible negative consequences. An evaluation of Health Canada's contributions to CDS stated that:

> *We must conclude that short-term initiatives such as the CDS Phase II are useful in that they inspire a higher sense of priority for a certain issue; at the same time, they hold inherent disadvantages in addressing an issue such as substance abuse, that is widely recognized to require a longer-term intervention than time-limited initiative funding will allow.* [31]

The following was also added:

> *The CDS Phase II Health Canada Component made a considerable investment in research and program development, and information monitoring systems. In many areas, Health Canada is now poised to reap benefits from the knowledge gained – however it is feared that this will not be the case due to non-renewal.*
>
> *There are also concerns that the sunsetting of the Health Canada component of the CDS will not only leave a void but see the balance in the federal harm reduction policy list too far in the direction of supply reduction, and that Canada's international credibility will also suffer.* [32]

The signatories were limited to federal departments and agencies, with Health Canada again responsible for providing national leadership and coordination. CDS still states that it reflects a balance between reducing the supply of drugs and reducing the demand for drugs. The long-term goal of the strategy remains unchanged: it is to reduce the harm associated with alcohol and other drugs to individuals, families and communities. The goals of CDS are to:

- Reduce the demand for drugs;
- Reduce drug-related mortality and morbidity;
- Improve the effectiveness of and accessibility to substance abuse information and interventions;
- Restrict the supply of illicit drugs and reduce the profitability of illicit drug trafficking; and
- Reduce the costs of substance abuse to Canadian society.[33]

---

[31] Health Canada, *Evaluation of Health Canada's Contributions to Canada's Drug Strategy: Final Report*, December 1996, pages 33-34.

[32] *Ibid.*, pages 34-35.

[33] Government of Canada, *Canada's Drug Strategy*, 1998, pages 4-5.

The strategy states that it is built on four pillars: prevention; enforcement and control; treatment and rehabilitation; and harm reduction. Within this general framework, seven separate components have been identified: research and knowledge development; knowledge dissemination; prevention programming; treatment and rehabilitation; legislation, enforcement and control; national coordination; and international co-operation.[34]

The Drug Strategy and Controlled Substances Program, within the Healthy Environments and Consumer Safety Branch of Health Canada, currently spends $34 million annually on substance abuse.[35] The Office of Canada's Drug Strategy currently manages $16.5 million of the $34-million total budget. The Alcohol and Drug Treatment and Rehabilitation program, which was originally managed by HRDC, was transferred to Health Canada in October 1997. It is currently managed by the Office of Canada's Drug Strategy, which provides $14 million to the provinces for treatment and rehabilitation programs. The other $2.5 million is allocated to the CCSA ($1.5 million) and for research and program management ($1.0 million). The remaining $17.5 million is allocated by the Healthy Environments and Consumer Safety Branch as follows: administration of regulations other than the Marijuana Medical Access Regulations ($5.0 million); Medical Marijuana Program ($5.0 million); drug analytical services ($4.5 million); policy, research and international affairs ($3.0 million).[36]

Health Canada does spend other resources on substance abuse through the department's varied activities. For example, the Population and Public Health Branch allocates resources to deal with HIV/AIDS and Hepatitis C, and to deal with FAS/FAE.

CANADA'S DRUG STRATEGY – A SUCCESS?

This section does not claim to provide an in-depth analysis of CDS since its implementation and development in 1987. Certain key objectives, however, will be reviewed in order to determine whether or not the CDS can be deemed a success. It is important to note that, despite the considerable amounts of money spent at the federal level to control psychoactive substances, many would argue that Canada does not even have a funded national drug strategy.

---

[34] While CDS deals with both licit and illicit substances, a separate strategy has been developed to identify specific approaches to tobacco.

[35] This does not include expenditures made by the First Nations and Inuit Health Branch, which total approximately $70 million.

[36] Health Canada, Presentation to the Special Committee on Illegal Drugs, 10 June 2002.

In 1997 the government implemented "Program Review", and severe financial cuts were applied to all departments, including Health Canada. The drug strategy did not escape these cuts and it sunset in 1997. In fact, there has been very little new money from the federal government for the field of addictions since.

Canada currently has no national strategy. We therefore simply do not have research data to guide us. In fact, no one knows the extent of drug consumption or prevalence in Canada because no national inquiry has been done since 1994. We therefore have to come up with hypotheses and resort to other tools to get a picture of the current situation in Canada.[37]

As mentioned, research, knowledge development and knowledge dissemination are severely lacking in Canada, despite the fact that these are intended to be key components of the CDS. A more complete analysis of these deficiencies in knowledge development and dissemination is set out in Chapter 6. To summarize, Canada has not given itself the means to conduct proper research and to acquire knowledge in this field. For example, only two general national drug surveys have been conducted - in 1989 and 1994. Much of the problem with respect to research and knowledge development can be attributed to the almost non-existent funding allocated to the CCSA. Considering the importance of the CCSA's role in knowledge development and the costs of substance abuse in Canada, it is clear that its funding has been totally inadequate over the years. The recent increase to its core funding may temporarily stop the bleeding but will not allow Canada to acquire the tools necessary to conduct vital and necessary research in this area.

The CDS has, since its implementation, stated that it reflects a balance between reducing the supply of drugs and reducing the demand for drugs. While such policy objectives are easy to pronounce, they have not been reflected in reality. The Auditor General has recently indicated that, of the approximately $500 million spent annually by 11 departments or agencies at the federal level to address illicit drug use in Canada, roughly 95% is spent on supply reduction. Notwithstanding the division of constitutional powers in Canada, one would be hard pressed to argue that this allocation of funds represents a balanced approach.

Another of the key objectives of the CDS is to ensure coordination and collaboration across all federal departments and with the provinces and municipalities. The Auditor General has recently criticized the leadership provided at the federal level and recommended a drug strategy with sound co-ordination and with clear objectives and results.

Canada requires stronger leadership and more consistent co-ordination to set a strategy, common objectives, and collective performance expectations. It must be able to respond quickly to emerging concerns about illicit drug use or the illicit drug trade. The present structure for leadership and for co-ordination of

[37] Michel Perron, *loc. cit.*, page71.

> *federal efforts needs to be reviewed and improved. The mechanisms for co-ordination with the provinces and municipalities also need review since they cross three levels of government.* [38]

One of the obvious weaknesses of the CDS is the failure to provide comprehensive evaluations of its objectives. For example, we are unaware of any evaluations of the prevention and treatment programs that have been funded by the federal government. This lack of evaluation is an overall concern.

> *Although the federal government provides leadership and co-ordination for dealing with the illicit drug problem, it has not produced any comprehensive reports that demonstrate how well Canada is managing the problem. It would be logical for Health Canada, as the lead department, to report government-wide results of Canada's efforts to reduce the demand for and the supply of illicit drugs.* [39]

In summary, it would be difficult to declare the CDS a success when we do not even have the tools needed to determine whether or not the objectives of the strategy have been satisfied. The current strategy has, at the very least, many fundamental weaknesses. As several critics have argued one must question whether we in fact even have a comprehensive drug strategy in Canada.

CONCLUSIONS

While we recognize that the federal government cannot act alone if it is to deal effectively with substance abuse problems, our conclusions with respect to a national strategy regarding psychoactive substances are generally limited to the role played at the federal level.

Conclusions of Chapter 11

- **Canada urgently needs a comprehensive and coordinated national drug strategy for which the federal government provides sound leadership.**
- **Any future national drug strategy should incorporate all psychoactive substances, including alcohol and tobacco.**
- **To be successful, a national drug strategy must involve a partnership with all levels of government and also with non-governmental organizations.**

[38] *Report of the Auditor General of Canada to the House of Commons* 2001, Chapter 11 – Illicit Drugs: The Federal Government's Role, page 1.
[39] *Ibid.*, page 22.

- **Over the years, the intermittency of funding has diminished the ability to co-ordinate and implement the strategy; adequate resources and a long-term commitment to funding are needed if the strategy is to be successful.**
- **Clear objectives for the strategy must be set out, and comprehensive evaluations of these objectives and the results are required.**
- **At the developmental stage, there is a need to identify clear and shared criteria for "success".**
- **The core funding for the CCSA has been insufficient for it to carry out its mandate; adequate funding for the CCSA is essential.**
- **There is a need for an independent organization – the CCSA – to conduct national surveys at least every second year; there is also a need to achieve some level of consistency, comparability and similar time frames for provincially based school surveys.**
- **Coordination at the federal level should be given to a body that is not an integral part of one of the partner departments.**
- **Canada's Drug Strategy's should adopt a balanced approach – 90% of federal expenditures are currently allocated to supply reduction.**

CHAPTER 12

THE NATIONAL LEGISLATIVE CONTEXT

Drugs have been prohibited for fewer than one hundred years; cannabis for slightly more than 75. It is tempting to think that the decisions made over the years to use criminal law to fight the production and use of certain drugs are in keeping with social progress and the advancement of scientific knowledge about drugs. Pre-twentieth century societies were less "advanced" and did not have the sophisticated tools that medicine, molecular biology and biochemistry, psychology and the cognitive sciences have provided over the course of this century of technological revolution. The prohibition measures adopted by parliaments, and on a wider scale, by the international community were therefore a more or less accurate reflection of the knowledge gradually acquired by scientists. The gradual conquest of territory occupied not so long ago by the irrational and its gang of charlatans and other shamans continued, for the greater good of humanity. As proof, phenomenal technical advances in medicine and pharmacology over the course of this century have resulted in increased longevity and decreased infant mortality in Western countries.

But is this really the case? Is civilization one long march towards progress, towards greater, and increasingly invincible, rationality? If we consider the state of the planet and the alarms sounded by more than one scientist today, we may have our doubts. From a social standpoint, the twentieth century has not brought fewer wars, less destruction, or more equality between people than previous centuries. With respect to drugs, is the legislation a more or less faithful translation of scientific knowledge for the greater good of all? Can we discern a rational structure in the national laws and international conventions that govern certain drugs and other substances? Are they based on knowledge of the effects of drugs on the psyche and human behaviour? Do they reflect the desire to ensure the well-being of the public?

The history of legislation governing illegal drugs in Canada, like the analysis in Chapter 19 of the structure of international conventions, suggests that this is highly doubtful. We do not deny that knowledge has advanced; the second part of our report testifies to this. But scientific knowledge itself is a structure that develops in a given historical context and responds to paradigms in the way problems are posed and research is conducted. The dominant scientific positivism is a temporary result in the long evolution of knowledge. It is not the "end of the story". Within the scientific process, a "selection" is made of pertinent questions and ways in which to ask them,

such that any question is not necessarily a good question and certain ways of answering are more acceptable to the community of researchers.

Moreover, legislation adopted by parliaments is influenced at least as much by prejudices and preconceptions resulting from "*pop science*" as by partisan, personal and international considerations. In this sense, the parliamentarian is no different from any other citizen, as we pointed out in the report's general introduction.

We were told several times that we could not compare the effects of cannabis to those of alcohol or tobacco. And yet, even at the risk of being unreadable if not unacceptable to the community, public policy on "drugs" must propose some rationale of the type: "this is prohibited, because…, and this is not, because…". Most of the time the "reason" – or the justification? – is presented as risks or dangers on the one hand and as medical usefulness on the other. Thus, under the current control regime, because of the risks or dangers they are believed to present, some drugs must be regulated, that is, they are not sold over the counter. When they present a danger **and** they have no known medical application, the regulatory controls prohibit their manufacture, production, growth, use, possession, etc., entirely. That is the case with the legislation and conventions governing opium and its derivatives (heroin), the coca plant and its derivatives (cocaine, crack) and the cannabis plant and its derivatives (marijuana, hashish). When the drug presents a danger but is medically useful, it is subject to more or less severe regulatory controls. That is the case with benzodiazepines and other powerful medications, which are sold by pharmacists and cannot be obtained without a medical prescription. Other drugs present a "health risk": nicotine, alcohol, as well as several other over-the-counter drugs. The packaging must indicate the risks (except for alcohol – which is very telling) so as to "warn" the user.

To what extent is such reasoning really rational?

> *Three researchers at the University of Toronto (Lazarou, Pomeranz, Corey, 1998) have estimated that* correctly prescribed *legal medications kill, on average, 100,000 people a year in North America. Although for methodological reasons that figure was cut back by one half or two thirds, it nonetheless illustrates the enormous losses of human life that go undetected by any monitoring system, including the legal system. No one thinks that this danger should be avoided by prohibiting medical prescriptions - the risky decisions made by physicians - or denying the "right to use" medications. Why? Because we do not see how that solution could be preferable to the solution of taking risks responsibly. Knowing that this problem exists, we will try to find other solutions, such as better quality control for the products, etc. Nor (fortunately) do we consider assigning criminal responsibility to physicians for taking the risk of writing a correct prescription, knowing that even correctly prescribed medications can cause death.* [1]

[1] Pires, A.P., (2002) *op. cit.*, page 43.

The 2001 report from the International Narcotics Control Board indicates a "worrisome" increase in the abuse of various prescription drugs in the United States and notes that several of these medications are found on the black market, in particular through the Internet.[2]

Tobacco use causes more than 400,000 deaths a year in the United States, and approximately 45,000 in Canada. As for alcohol, it is linked to physical aggression and violence, especially marital, and to road accidents, and its abuse causes thousands of deaths each year.

> *It is a mistake to see illegal drugs in a separate category from the legal drugs insofar as the history of criminalization is concerned. We have compounded that difficulty today because we do not tend to see the legal drugs in the same limelight as the illegal drugs. To demonstrate that, we use the phrase "alcohol and drugs" as if alcohol were not a drug, as if police officers who go to domestic disputes do not know already that the major drug problem they will likely find at that dispute is alcohol abuse, as if we do not already know that more than 70 per cent of all homicides involve alcohol abuse as a critical factor. For us to pretend that the consumption of alcohol is on a morally different plane from the consumption of illegal drugs seems to be a kind of cultural folly that speaks volumes about the cultural blinders we wear as we go about our business in everyday life.*[3]

Is the rationale of the system of controls acceptable in the eyes of civil society, users as well as abstainers? What criteria motivated the legislators' decisions? For that matter, were there any criteria? What motivated parliamentarians from Canada and elsewhere to prohibit certain substances, to control access to certain others, and to permit still others to be sold over the counter?

Knowing where you have been helps you to understand where you are going. That is the goal of this chapter, which retraces the evolution of Canadian drug laws from 1908 to the present day.[4] We have identified three legislative periods. The first, and longest, spans the years from 1908 to 1960. That is the period of hysteria. The second, which is much shorter, runs from 1961 to 1975 and is the period involving the search for lost reason. Lastly, the contemporary period, which really starts at the beginning of the 1980s, is the period of forging ahead regardless. As it would be too much to describe the different sections in the various bills adopted over the years, we have appended a table that explains and presents the clauses of the legislation adopted from 1908 to 1996 on the control of narcotics.

---

[2] INCB (2002) pages 58-60 in particular.

[3] Testimony by Neil Boyd, Professor of Criminology, Simon Fraser University, before the Special Senate Committee on Illegal Drugs, Canadian Senate, Second Session of the Thirty-Sixth Parliament, October 16, 2000, Issue 1, page 49.

[4] This chapter is based largely on the excellent report prepared at the Committee's request by François Dubois, research assistant to Senator Pierre Claude Nolin: *Le Parlement fédéral et l'évolution de la législation canadienne sur les drogues illicites*, Ottawa: Special Senate Committee on Illegal Drugs, June 2002. This report is available on line at www.parl.gc.ca/illegal-drugs.asp

1908-1960: HYSTERIA

At the time of the Shanghai Conference on opium in 1909[5], European societies had known for hundreds of years about opium, coca leaves, and cannabis, having discovered them through contact with other societies. These "drugs" were used in medical practice, as well as by a certain worldly or artistic elite, and especially as a commercial tool by colonial powers. In the midst of advances in chemistry, the 19th century saw the arrival of a large number of new drugs–primarily opiate-based–and their enthusiastic adoption by physicians, pharmacists, general store owners and traveling salesmen as miracle elixirs. What happened so that Canada in 1908, and the seven countries gathered in Shanghai in 1909, decided to prohibit this "drug"? At least four factors figured in the game of chance and necessity that led to prohibition.

First of all, geopolitical issues, commercial dealings with China in particular and the political stability of the Middle Kingdom in general, played a considerable role, as shown in Chapter 19. But from a domestic standpoint, these factors do not explain everything, especially since the concerns of the Dominion of Canada and its people about international politics were still relatively minor.

Initially, physicians noticed, sometimes from their own experience as a user, that use of opium derivatives resulted in a certain degree of dependence and health problems.[6] At first, these cases of drug addiction were limited to the leisured classes and to artists, who were rarely labeled as "delinquents". However, the increasing availability of these drugs[7] and the subsequent development of dependence problems within the working classes had a profound effect on public opinion about these drugs. There was no longer talk of "the ill" but rather of "delinquents" who [translation] "*could not face up to the demands of life as a good citizen and worker*"[8]. A few doctors, worried about protecting their monopoly, did not hesitate to demand laws from the government to restrict the use of drugs produced by pharmaceutical companies and thus avoid the propagation of this "scourge" that threatened the foundation of North American society.

---

[5] See Chapter 19 for more details.

[6] We note in passing that in fact these were synthetic opium derivatives such as morphine. It was not discovered until much later that smoking heroin was much less harmful to the user than injecting it or using its synthetic derivatives. We can also draw a parallel with synthetic derivatives of cannabis, which cause more problems than smoking cannabis, as we saw in Chapter 9.

[7] Line Beauchesne talks about large pharmaceutical companies that flooded the market by manufacturing these products en masse and then trying to dispose of them in any way possible. Beauchesne, L., (1991) *La légalisation des drogues… Pour mieux en prévenir les abus.* Montreal: Méridien, pages 95-96.

[8] Beauchesne, L. *op. cit.*, page 98.

Even though the use of opium did not result in a social crisis before the beginning of the 1880s, whites who frequented Chinese opium dens were often seen as suspicious or dangerous. At the time, [translation] "*Frequenting the Chinese quarter and its opium dens is seen by several moral groups as a preference for the foreign, as willingly straying from white Anglo-Saxon values. This judgment is even more severe where women are concerned.*" [9]

Associated with the problem of alcoholism in the working classes, the question of the use of drugs then became the metaphor par excellence for the decay of western Judeo-Christian civilization, and the favourite theme of temperance leagues in the United States as well as Canada. Born in the 19th century, these movements had a very strong religious basis, especially in the protestant ethic of responsibility for personal health through work and self control: [translation] "*work and sobriety were valued as a means to avoid loss of production and to maintain the economic superiority of the white Anglo-Saxon race.*"[10] Waging "war" against alcohol that causes male violence and adultery, against drugs that kill young people, and also against prostitution, cigarettes and gambling suited these movements perfectly.[11] From community support groups designed to help those who wanted to break their bad habits, these leagues transformed themselves into powerful pressure groups demanding the complete prohibition of alcohol first, and then supporting the prohibition of opium and other drugs.

The third factor, closely related to the previous two, was population movement and especially Chinese immigration – it would be more accurate to talk about the importation of Chinese workers. The Chinese had immigrated to the United States in the middle of the 19th century to work in the mines and build the railroads in the American West. Once these large projects were completed, certain labour disputes broke out on the American West Coast, pitching the Chinese, who offered cheap labour to owners of agricultural enterprises, against powerful unions, largely composed of white workers. Following the appearance of the union-based anti-Chinese movement and legislation that prevented any further Chinese immigration, many Chinese had no choice but to develop the opium trade in the ghettos where they lived in large American cities. The temperance movement did not hesitate to adopt the racist feeling driving certain segments of American society in order to denounce the use of opium, seen as a scourge that promoted immorality, crime and the decline of the white Anglo-Saxon race. It was in this context of social unrest, although limited to the American West Coast, that the first American legislation governing the opium trade was adopted.

In Canada, in the middle of the 19th century, the Chinese became a major source of manpower for building the Canadian Pacific Railway. As the economy of British Columbia diversified, these immigrants found work in fish processing plants, coal mines and the forestry industry, although the jobs available to them remained limited.

---

[9] *Ibid.*, page 126

[10] Beauchesne, L. (1999) "À propos du cannabis, que faire?" *L'écho-toxico*, page 14.

[11] Ati-Dion, G., (1999) *The Structure of Drug Prohibition in International Law and in Canadian Law (Doctoral Paper)*, Montreal, Université de Montréal, École de criminologie, page 24.

This worsened the competitiveness of the local labour market and increased their marginalization in society.[12] Beginning in the 1880s, the massive influx of Chinese juxtaposed with the economic slowdown brought on by the end of construction of the Canadian Pacific railway and the economic recession that marked the end of the 19th century and the early years of the 20th century caused several union and popular demonstrations demanding the end of Chinese immigration, the source of British Columbia's economic and moral problems.

According to Giffen, this fear was not justified since white immigration from other regions of Canada more than offset the increase in British Columbia's Chinese population. In fact, the proportion of Chinese in the province declined from 20% at the beginning of the 1880s to less than 6% in 1921[13], just before a clause in the *Opium and Narcotic Drug Act* was adopted authorizing the deportation of an immigrant found guilty of a drug-related offence.

But,

> *Tolerance for the habit of smoking opium lasted only as long as British Columbia's tolerance for the Chinese. In the early years of the twentieth century, both a labour surplus and anti-Asian resentment developed. The Asiatic Exclusion League was formed, supported by an amalgamation of the Vancouver Trades and Labour Council and federal Conservative politicians. Opposed to the Liberals' immigration policies [under Sir Wilfrid Laurier], the league demanded an end to immigration from Asia, claiming that the "yellow peril" was about to "swallow" a white British Columbia.* [14]

In fact, well before the development of this "social crisis", the British Columbia government had tried to halt Asian immigration by adopting the *Chinese Immigration Act* in 1884, which imposed an annual tax of $10 on the Chinese and other Asians living in British Columbia and prohibited them from buying land belonging to the province. The federal government disallowed this Act, but in 1885 it created a Royal Commission to investigate Chinese immigration and this commission recommended imposing a $10 entry tax on every Asian immigrant. In 1885, as a result of public pressure, the federal government adopted the *Chinese Immigration Act*, which imposed a $50 entry tax that was increased to $500 in 1904, as many had criticized the fact that despite the imposed tariff, 20,000 Asians had immigrated to the country between 1889 and 1900.

A major incident in 1907 led the federal government to intervene in matters of Chinese immigration and labour disputes in British Columbia. During the year, a demonstration organized by the *Asiatic Exclusion League* and attended by more than 10,000 people, most of whom were union workers and members of the middle class, turned into a riot when the angry crowd headed into Vancouver's Chinese district, attacking people and causing serious property damage. After convincing Prime Minister

---

[12] Giffen, P.J. et al., (1991) *Panic and Indifference: The Politics of Canada's Drugs Laws*, Ottawa: Canadian Centre on Substance Abuse, page 53.

[13] *Ibid.*, page 53

[14] Boyd, N. (1991) *High society: Illegal and Legal Drugs in Canada*, Toronto, Key Porter Books, page 27

Laurier of the wisdom of compensating the Chinese, William L. Mackenzie King, then Deputy Minister of Labour, returned to Vancouver in the Spring of 1908, where he wrote a report[15] that would lead to the adoption of the *Opium Act.* Based primarily on moral, ethical, political, diplomatic and ethnic considerations, Mackenzie King's report, rather than attacking labour disputes between white and Chinese workers, shifted the problem to opium use by Asian foreigners.

> *[...] the amount [of opium] consumed in Canada, if know, would probably appall the ordinary citizen who is inclined to believe that the habit is confined to the Chinese, and by them indulged in only to a limited extent. The Chinese with whom I conversed on the subject, assured me that almost as much opium was sold to white people as to Chinese, and that the habit of smoking opium smoking was making headway, not only among white men and boys, but also among women and girls.* [16]

As in the United States, Chinese immigrants brought with them not only their labour but also their practice of smoking opium. They preferred this practice to the widespread habit of white workers of using alcohol and opiate-based drugs to cure illnesses and to momentarily forget their social and working conditions.[17] Thus the first opium den opened its doors in Vancouver in 1870. Some Chinese even opened factories to produce opium for smoking; the opium was then used in opium dens in Vancouver's Chinese district or was simply sold to white clientele. As Professor Boyd mentioned during his testimony before the Committee:

> *Over time, equal amounts of smoking opium were sold to whites as to Chinese. If you look back through the issues of Vancouver Province or the Victoria Times Colonist, you find advertisements. You do not find any expression of concern or anger about those smoking opium establishments, but you find advertisements.* [18]

In 1883, there were three factories producing smoking opium in Victoria and in 1891, there were more than 10 opium dens in the Chinese districts of large cities in the Canadian West.[19] The surge in this industry was beneficial to the British Columbia government since it imposed a customs tariff on crude opium of 10% to 25%.

> *If I could turn back the clock 100 years to Vancouver, Victoria and New Westminster, I could show you opium-smoking factories which were started in the late 1870s and persisted for 30 years without complaint. The labour surplus and the depression in the first decade of the 20th century led to concerns that led to the original legislation. It is noteworthy that the Opium and Narcotic Drug Act of 1908 was*

---

[15] William L. Mackenzie King, *The Need for the Suppression of Opium Traffic in Canada.* Ottawa, Parliamentary Document 36b, 1908, 18 pages

[17] Beauchesne, L., (1991) *op. cit.*, page 125

[18] *Ibid.*

[19] Giffen, P.J. et al., (1991) *op. cit.* page 125

> *introduced by the Minister of Labour. When he introduced the act, he said, "We will get some good out of this riot yet," referring to the anti-Asiatic riot in Vancouver in September of 1907.*
> *Imagine, today, the idea of illegal drug legislation coming forward from the Minister of Labour because he or she is seeking to get some good out of a labour crisis on Canada's West Coast. The situation in California was similar.*[20]

Even though the Royal Commission of 1885 did not recommend specific measures governing the production or use of smoking opium, it did indicate that smoking such a substance was a pagan practice incompatible with the lifestyle of a Christian nation.[21] According to Line Beauchesne, the crusade against opium that followed this report gradually resulted in a decline in opium smoking.[22] The results of an investigation conducted by the *American Pharmaceutical Association* in 1903 into drug use claimed that drug consumption was widespread throughout American society, but involved two social groups more specifically: Chinese immigrants and Blacks. This study probably influenced some federal politicians and temperance movements that used similar arguments until the beginning of the 1930s to justify the prohibition of opium and other drugs.[23]

In short, while economic considerations were at the heart of anti-Asian feeling, temperance movements and religious groups took advantage of the situation to promote their views, not only in the immediate area of British Columbia but also across the rest of the country. These events drew the public's attention to the "dangers" of opium for Canadian society.

Opium Act, 1908

In the House of Commons on July 10, 1908, the Minister of Labour proposed the adoption of a motion prohibiting: *"the importation, manufacture and sale of opium for other than medicinal purposes."*[24] The motion was adopted without debate. The Minister introduced Bill 205, *An Act to prohibit the importation, manufacture and sale of opium for other than the medicinal purpose.* (*Opium Act, 1908*).[25] The first section of the Act prohibited the importation of opium without authorization from the Minister of Customs. Additionally the drug could be used for medical purposes only. The manufacture, sale and possession for the purpose of selling crude opium or opium prepared for use by smokers was also prohibited. Whoever violated these provisions could be found guilty of a criminal offence punishable by a maximum prison term of three years and/or a

---

[20] Testimony by Neil Boyd, Professor of Criminology, Simon Fraser University, before the Special Senate Committee on Illegal Drugs, Canadian Senate, Second Session of the Thirty-Sixth Parliament, October 16, 2000, Issue 1, page 49.
[21] Beauchesne, L., *op. cit.* page 128
[22] *Ibid.*, page 128
[23] Ati-Dion, G., (1999) *op. cit.* page 25
[24] Hansard, House of Commons, July 10, 1908, page 12550
[25] Statutes of Canada 1908, c. 50

minimum fine of $50 and not exceeding $1,000. Even though it prohibited the use of opium, the legislation was aimed at opium dealers, most of whom were Chinese, and not users. The bill was given Royal Assent on July 20, 1908.

The Opium and Narcotic Drug Act, 1911

The enactment of the *Opium Act* led to the introduction of 8 new bills intended to make it both more restrictive and effective on January 26, 1911, Mackenzie King, who had just become the Minister of Labour, introduced Bill 97, an *Act to prohibit the improper use of Opium and other Drugs* (the *Opium and Narcotic Drug Act, 1911*).[26] During the deliberations on second reading, Mackenzie King gave three reasons for introducing the bill: the Shanghai Commission, the panic in Montreal caused by cocaine use and the need to grant special powers to the police to ensure that the Act could be enforced effectively. The Shanghai Commission had adopted a number of non-binding resolutions, including: putting a gradual stop to the opium smoking habit, with due regard to the specific circumstances of each country; prohibiting the use of opium and its alkaloids and derivatives (morphine, heroin, etc.) and other drugs for non-medical purposes; and prohibiting the export of these substances to countries that prohibited their use.

No member raised any objections about the four drugs added to the Schedule to the Act, namely cocaine, opium, morphine or eucaine. Section 14 of the Act also provided that the Governor in Council had the power to order any alkaloid, by-product or drug preparation added to the Schedule when its addition was deemed necessary in the public interest–*a power which still exists today*. The justification given for this was that if the use of a new drug were to become widespread in society, it would be possible to add it more quickly to the Schedule than by having to enact new legislation.[27] Other provisions of the Act related to the use of opium, search powers granted to the police, orders for the confiscation or restitution of seized drugs and a reverse onus for cases of simple possession of drugs. The possibility of requesting that a higher Court issue a writ of *certiorari* with respect to prosecutions carried out under this Act was eliminated.

The post-war period led to a string of major amendments to the offences, penalties, police powers and criminal procedure provided in the *Opium and Narcotic Drug Act*. There are several factors to explain this legislative ferment: the concerns raised by Emily Murphy's writings about the extent of the "scourge" of drugs in Canada[28]; the renewed conflicts between Whites and Asians in British Columbia; the mobilization of doctors' and pharmacists' associations to prevent the Act from infringing on their activities; the establishment in 1919 of the Department of Health and the powerful Narcotics Division (the predecessor of the current (Office of Controlled Substances), which were responsible for enforcing international conventions on drugs in Canada; the

[26] Statutes of Canada 1911, c. 17

[27] Hansard, House of Commons, January 26, 1911, page 2549.

[28] This was discussed in Chapter 10.

establishment in 1919 of the Royal Canadian Mounted Police (RCMP), responsible for enforcing the *Opium and Narcotic Drug Act*, the enactment of the *Harrison Narcotic Act* in the United States in 1914; and the mobilization of the international community to enforce the *International Opium Convention* (The Hague - 1912) imposed on a number of countries by the 1919 Treaty of Versailles.

The establishment of the narcotics division

The enactment of the *Harrison Narcotic Act* in the United States and the mobilization of the international community to enforce The Hague Convention quickly brought to light three major shortcomings of the *Opium and Narcotic Drug Act*, 1911.[29]

The first problem appeared when the time came to control drug imports and exports. The Act had only vague instructions concerning trading in drugs for medical or scientific purposes. That being the case, customs officials were reluctant to seize cargo containing opium or other drugs.

The second problem stemmed from the enactment in the United States of the *Harrison Narcotic Act*, which was similar to the Act passed in Canada in 1911. However, it imposed a system of licences issued to businesses by the federal government authorizing them to import or export drugs. This led to a significant demand for illegal drugs in the United States. As the supply of these substances in Canada exceeded consumer demand, traffickers quickly took advantage of this business opportunity and exported their surpluses to the United States. This had become so profitable that in 1918, a committee of the US Senate filed an official complaint with the Canadian government concerning drug trafficking.

The third and final problem stemmed from the fact that traffickers quickly found ways to avoid the provisions of the 1911 Act because its enforcement was not centralized within a single government agency. On the one hand, Customs was attempting as best it could to control legal trade in drugs whereas on the other hand, municipal police departments handled illegal trafficking, which was becoming increasingly sophisticated every year, requiring that new powers be granted to the police.[30]

The many amendments to the Act to deal with these problems were orchestrated in part by F. W. Cowan the first Chief of the new Narcotics Division (1919-1927) of the Department of Health, and in particular by Colonel C. H. L. Sharman, the former RCMP officer who succeeded him (1927-1946). Cowan quickly understood after becoming Chief of the new division that he would have to centralize control over both legal and illegal trade in drugs to ensure that the Act could be enforced effectively, thereby assuring the long-term survival of his organization. During his tenure, an impressive communications network was created, and by the end of the 20s, it included the other divisions of the Department of Health, the Department of Justice and the

[29] Giffen, P.J., et al., *op. cit.*, page 105.
[30] *Ibid.*, pages 105-121.

lawyers hired to prosecute drug offences, the RCMP, the media, municipal police departments, associations representing doctors and pharmacists, governments and agencies responsible for enforcing the laws of other countries, including the United States, and international narcotics control agencies established by the League of Nations.

Under Sharman's impetus, the administration of information from all of these participants was eventually conducted solely by the Division, and no longer by the Department of Justice or the RCMP. This made it possible for the director to have an overall picture of the narcotics situation, thereby making him an "expert" in the field. A former official of the Division described Colonel Sharman as "*a Czar running an empire of his own.*"[31] His influence grew when the Division was placed under the authority of the Deputy Minister of Health. The reorganization fostered a closer and more direct relationship with the Minister and Members of Parliament, making it possible for him to short-circuit proposals from other divisions within the Department. And when the time came to add further offences, penalties, criminal procedures or new police powers in the 20s, the Division never hesitated to take advantage of the "panic" generated by the media in Vancouver, or Emily Murphy's writings, to justify such amendments.[32]

From the standpoint of enforcing the Act, this structure was very useful. For example, up until the 50s, from the moment a police officer or a lawyer, anywhere in Canada, informed the Chief of the Division of a weakness in the Act, he would draft proposed amendments, pass them on to his network for rapid consultation, and if necessary, he would encourage the Minister of Health to introduce a bill to correct the problem situation. The federal drug bureaucracy as we know it today was born!

In such a context, the establishment of a network like this had a significant impact on the direction that would be taken by Canadian narcotics legislation:

> *In short, the establishment of an administrative organization to enforce narcotic law had the unintended consequence of creating a centralized pressure group which had the motivation and influence to play a major role in shaping the future course of the legislation. This centralization of power and expertise together with the fact that the resources were directed mainly at a socially powerless group helps to explain the virtual absence of an effective criticism and alternative proposals for control from 1920 to 1950.*[33]

Amendments to the Opium and Narcotic Drug Act (1920-1938)

Many amendments were made to the 1911 Act prior to an in-depth overhaul of the Act in 1938. It was during this period that cannabis was added to the schedule of the Act.

[31] *Ibid.*, page 144.
[32] *Ibid.*, pages 138-146.
[33] *Ibid.*, page 127.

Amendments to list of substances in schedule: Addition of cannabis

From 1911 to 1938, many drugs were added to the schedule of the *Opium and Narcotic Drug Act.* The 1911 Act was introduced to control only four drugs. In 1938, when the *Act to amend the Opium and Narcotic Drug Act*[34] was enacted, the schedule listed more than 15 drugs, including derivatives or salts, one of which was cannabis, added in 1923.

During a sitting of the Committee of the Whole in connection with a review of the 1923 Act, Minister of Health Henri-Séverin Béland simply said about the substance that, "*There is a new drug in the schedule.*" [35] That is how cannabis ended up in the schedule to the Act. According to Giffen, the circumstances leading to the decision remain obscure because, until 1932, the issue of the effects of cannabis on people's physical, psychological or mental health had never been raised in Parliament. Giffen described the criminalization of the drug as a solution without a problem.

In the United States, beginning in 1890, some American doctors were worried that the potency of cannabis appeared to be variable and that individual reactions when cannabis was taken orally appeared to be unpredictable. Thus despite the continued use of much more dangerous drugs like barbiturates and opiates, cannabis was abandoned by doctors. At the beginning of the century, the discovery of the hallucinogenic nature of cannabis contributed considerably to its reputation as a dangerous drug. However, the people who wrote the *Harrison Narcotic Act* had not deemed it appropriate to subject it to the controls provided in the Act.[36] But in 1915, California became the first American state to prohibit the use of marijuana, and in the early 20s, marijuana had "become a major 'underground drug' traced to an influx of Mexican workers into Southern United States in the 1910s and 1920s."[37] As with opium, labour disputes, the economic interests of big business and morality served as catalysts to create a popular movement in favour of the prohibition of cannabis in the United States, which led to the passage of the *Marijuana Tax Act* in 1937, prohibiting the use and production of cannabis.

Unlike in the United States, there were no reliable accounts of the non-medical use of cannabis in Canada before the 1930s.[38] And unlike California, Canada was not faced with an influx of Mexican workers. Why then was cannabis added to the Opium Act schedule?

In 1922, Emily Murphy referred to the harmful effects of cannabis on human behaviour in her book *The Black Candle*, in which she worked over most of the articles she had published in *MacLean's* magazine. In the chapter entitled "*Marihuana – A New*

---

[34] Statutes of Canada, 1938, c. 9.

[35] Hansard, House of Commons, April 23, 1923, page 2117.

[36] Beauchesne, L., (1991) *op. cit.*, page 117.

[37] Spicer, Leah, (2000) *Historical and Cultural Uses of Cannabis and the Canadian "Marijuana Clash"*. Ottawa: Law and Government Division, Library of Parliament, Report prepared for the Senate Special Committee on Illegal Drugs, p. 20, available online at www.parl.gc.ca/illegal-drugs.asp

[38] *Ibid.*, page 21.

Menace" she reported comments made by the Chief of the Los Angeles Police Department, who described the terrible effects of cannabis.

But Giffen's research in the archives of the Department of Health indicates that these scare tactics, which were steeped in morality, were not behind the placing of cannabis in the *Opium and Narcotic Drug Act* schedule, particularly given that at the time, it was virtually unknown in Canada and its use was not a problem.[39] This is confirmed in section 7 of the 1932 Act, which amended a provision of the 1920 Act by allowing the manufacture, sale or distribution, without a permit, of medicines if they contained only small quantities of certain drugs listed in the schedule. In 1932, the measure would henceforth apply to cannabis. During parliamentary debate on the introduction of this statute, the discovery of the existence of this drug appeared to elicit the interest of certain parliamentarians. During Committee of the Whole, MP Ernest Lapointe asked the Minister of Health, "*What is cannabis sativa?*", and the Minister replied "*Hitherto this was a drug which was not included in the list which might be used. It is one form of the drug used in India which, I believe, goes under the popular name of hashish. There is no objection to the use of it ....*"[40]

In short, it is remarkable that, over seventy-five years later, we should still not know why cannabis was placed on the list of prohibited drugs. On the other hand, no shortage of "reasons" were found in the years that followed.

Under the influence of American media campaigns, which were taken up by Canadian newspapers, and of horrifying accounts by police officers about young Canadians who were physically and mentally destroyed after using cannabis, the attitude of federal parliamentarians towards the drug would become less and less tolerant. The 1938 Act, enacted one year after the passage of the *Marijuana Tax Act* in the United States, was the end result of this "new panic". Section 3 of the Act prohibited anyone from growing cannabis or opium poppy without first having obtained a permit from the Department of Health. The penalties for this new offence were the same as those provided for trafficking in, and simple possession of, cannabis. This measure was unusual because Canada, for the first time, had climate conditions conducive to the growing and production of a drug, which it did not for the other drugs in the schedule. An analysis of parliamentary debates shows that the Department of Agriculture conducted scientific experiments on industrial hemp by growing cannabis at the Experimental Farm in Ottawa and at another research centre near Montreal. A number of entrepreneurs in Ontario were still growing hemp. The 1938 Act put an end to the practice.

Following the introduction of the Bill, Minister of Health Charles Power said in connection with section 3: "*The proposed amendments deal to a considerable extent with the attempt which is being made by the department to control what, though it cannot be called a new drug,*

---

[39] Giffen, P.J. et al., *op. cit.* page 179.

[40] Hansard, House of Commons, 1932, page 1792.

is a new menace to the youth of the country".[41] Later, he said that it was very dangerous to smoke marijuana cigarettes. To demonstrate his comment, he cited a report prepared by Harry J. Anslinger, the first commissioner of the *Federal Bureau of Narcotics*, in which the drug was described as, *"the assassin of youth ... one of the greatest menaces which has ever struck that country."*[42] The Minister of Health nevertheless said that the situation in Canada was not as serious as in the United States. The statements by the Minister of Health about the harmfulness of cannabis were not disputed by any members, even though no research was put forward in defence of the statements made.

The most important amendments to the schedule were made in 1932, following the enactment of the *Act to amend the Opium and Narcotic Drug Act, 1932*.[43] In the amendments, over 10 psychoactive substances were added to the schedule, both natural drugs (like coca leaf) and synthetic drugs. The inclusion of these substances coincided with the adoption in 1931 of the *Geneva Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs*, with Colonel Sharman making a major contribution to the negotiations leading to the signing of the convention. It was also at this time that Canada had begun to play an active role internationally with respect to drugs in support of the efforts of the United States and Harry J. Anslinger to better control international drug trafficking, particularly in the producing countries.[44]

During the debates on the enactment of the 1932 Act, which would implement the provisions of the 1931 Convention into Canadian law, no questions were asked of the Minister of Health, Murray McLaren, concerning the reasons leading the Minister to include the above-mentioned drugs in the schedule.

Amendment of penalties

The penalties for trafficking or illegal possession of narcotic drugs were amended several times during this period. Furthermore, other offences were created as trafficking techniques to get around the law became increasingly sophisticated. According to Giffen, there were several reasons why the authorities responsible for enforcing the Act wanted more flexibility:

> *"Latitude in regard to penalties helped to overcome the reluctance of the courts to convict in cases of lesser culpability and respectable social status; such cases were inevitable in the early years when the addict population was still relatively heterogeneous. Moreover, popular support for the law was more likely to be maintained if sentences that were regarded as unjust by local people could be avoided."*[45]

---

[41] Hansard, House of Commons, February 24, 1938, page 772.

[42] Hansard, House of Commons, February 24, 1938, page 773.

[43] Statutes of Canada, 1932, c. 20

[44] Sinha, Jay (2001) *The History and Development of the Leading International Drug Control Conventions*. Ottawa: Library of Parliament, Law and Government Division, report prepared for the Senate Special Committee on Illegal Drugs, page 15. Available at www.parl.gc.ca/illegal-drugs.asp

[45] *Ibid.*, page 199.

This flexibility gave more options to the police and Crown attorneys allowing them to negotiate guilty pleas more easily, to decide on the type of proceeding or to make use of people who had been charged as informers or undercover agents by promising them a reduced sentence or the withdrawal of the charges. In some instances, it also allowed for minimum sentence thereby reducing the Court's discretion during sentencing. The increase in the severity of penalties also sent a clear message to judges about the severity and level of social reprobation for drug offences. The possibility of proceeding by summary conviction also reduced the time period between the arrest and the sentencing. This made it possible to significantly increase the number of convictions. This was particularly important, because the higher the number of convictions, the more the people would be able to see the extent of the problem and the effectiveness of the act.[46]

The 1911 Act provided for a maximum sentence of imprisonment of one year and/or a maximum fine of $500. In 1920, after the *Act to amend the Opium and Narcotic Drug Act, 1920*, was passed[47], a minimum fine of $200 was assessed with the maximum increased to $1,000. In 1921, the *Act to amend the Opium and Narcotic Drug Act, 1921*,[48] significantly amended the penalty for this type of offence. Hybrid offences were created (summary conviction and indictment) for these two illegal activities. For an indictment, a maximum term of imprisonment of seven years could be imposed. For a proceeding by summary conviction, the maximum prison sentence was increased to 18 months, with the possibility of an additional 12 months for default of payment of any fine assessed by the Court. In 1922, the *Act to amend the Opium and Narcotic Drug Act, 1922*,[49] amended the sentence of imprisonment for a summary conviction by providing for the imposition of a minimum prison sentence of six months. In 1925, Parliament passed an amendment providing for the imposition, at the judge's discretion, of a sentence of forced labour for a summary conviction, for simple possession of a drug.

In 1921, an offence was created for the sale, gift or distribution of drugs by a trafficker to a minor. In such cases, one could only proceed by way of indictment and anyone convicted could receive a maximum prison sentence of seven years. Following a highly emotional debate, the sentence of whipping, which had been suggested by a Member, was withdrawn. However, the next year, while reviewing the 1922 Act in the Committee of the Whole, the same member once again suggested the imposition of a sentence of whipping for traffickers selling drugs to minors. At the end of the debate, the Minister of Health agreed to add the penalty of whipping to the Act. In 1929, federal parliamentarians stated their opinions about extending the punishment of whipping to trafficking and simple possession of drugs, as provided for in the *Act to amend and consolidate the Opium and Narcotic Drug Act, 1929*.[50]

---

[46] *Ibid.*, pages 199-200

[47] Statutes of Canada, 1920, c. 31

[48] Statutes of Canada, 1921, c. 42

[49] Statutes of Canada, 1922, c. 22

[50] Statutes of Canada, c. 49.

Another important penalty was introduced in the 1922 Act: the deportation of immigrants. Section 5 of this statute provided that, except as may otherwise be provided in the *Immigration Act*, any immigrant convicted of trafficking, simple possession or selling drugs to a minor could be deported from Canada. From 1922 to 1944, when the last immigrants were deported for drug offences, over 1,082 Chinese (82%) were deported, compared to 163 Americans (13%) and 68 other persons of various ethnic origins (5%), for a total of 1,313 deportations. In 1930, the "panic" in British Columbia was a thing of the past, but during the previous eight years, over 638 Chinese had been deported by the Canadian authorities.[51]

There were other offences as well in the legislation, for example possession of pipes, lamps or any other equipment for the preparation or use of opium; drug trafficking by mail; and obtaining drugs by consulting two doctors. Between 1922 and 1930, 7,096 persons were convicted for an offence under the *Opium and Narcotic Drug Act*. Of these, over 4,900 were Chinese, or 69%.[52]

Police powers

From 1920 to 1930, various amendments to the *Opium and Narcotic Drug Act* led to the police being granted new powers. These amendments specifically had to do with powers of search. Section 7 of the 1911 Act provided for the issuance of a search warrant authorizing police officers who had reasonable grounds to search the following kinds of premises: a dwelling-house, shop, boutique, warehouse, garden or ship, and to seize drugs found there as well as any containers in which the drugs had been found. Section 3 of the 1922 Act provided for the possibility of conducting a search for drugs without a warrant, either during the day or at night, in the above-mentioned premises. However, police officers were required to have a warrant to search a dwelling-house.

Section 8 of the 1911 Act provided that any drugs seized and the containers in which the drugs were found could be confiscated and delivered to the Court, and be destroyed after the accused's conviction. However, section 9 imposed a number of conditions on the procedure provided under section 8. Indeed, if the person charged was acquitted, there was a three-month period during which the Court could be asked to issue an order to give back the seized drugs. If they were not claimed during this period, they were to be destroyed. The 1921 Act slightly amended these two provisions by specifying that henceforth, drugs and the containers in which they were found were to be confiscated and turned over to the Department of Health, which would dispose of them as it saw fit. This amendment was deemed necessary by the Narcotics Division because several judges, rather than order the destruction of the goods, sent them to hospitals. The Division was afraid that the drugs so returned might fall into the hands of traffickers.

---

[51] Giffen, P.J. et al., *op. cit.*, page 596.
[52] *Ibid.*, page 594.

In 1923, the powers to search and the orders of forfeiture were extended to vehicles in which drugs were found. In 1929, this procedure was extended to all traffickers' vehicles, whether or not any such substances were found in them. The purpose of this was to impede the activities of traffickers and to prevent their vehicles from being used by other criminals after they were convicted. The procedure was later extended to aircraft. In 1925, Parliament, by enacting the *Act to amend the Opium and Narcotic Drug Act, 1925*,[53] authorized police officers to search any person found on the premises searched, with or without a warrant.

The 1929 Act granted special search powers to police officers. Section 22 of this statute allowed a writ of assistance to be issued to a police officer. This was a general power, without any restrictions of time or place, to remain valid throughout the career of the peace officer. Such a writ authorized its recipient to enter a dwelling-house at any time of the day or night accompanied by whatever persons were deemed necessary to conduct searches and seize drugs. The writ of assistance thus made it possible to get around the prohibition on searches and seizures of drugs in a dwelling-house without a warrant. At the same time, the Act was amended to authorize police officers, during searches or seizures, with or without a warrant, to use force if required to conduct a search and to be assisted by persons other than peace officers.

Criminal procedure

In the 1920s, another major amendment was introduced to facilitate convictions in drug cases, a reverse onus provision. The onus was now on the accused, not on Crown prosecutors, to prove that he had not committed the crime with which he was charged. Under British criminal law, the task of proving an accused's guilt traditionally falls on the Crown, hence the expression "presumed innocent until proven guilty".

Section 10 of the Act of 1911 provided that, in a prosecution for drug possession or trafficking (with the exception of importing and exporting), in order to be acquitted, the accused had to prove that he had a legitimate excuse or that he had used such substances for therapeutic or scientific purposes. When Parliament amended the Opium and Narcotic Drug Act in 1920 to provide a better framework for dealing with importing and exporting, the manufacture, sale and prescription by physicians of scheduled drugs by means of a permit, the procedure established in 1911 was amended to specify that, in order to be acquitted, the accused had to prove that he had had a permit duly issued by the Department of Health.

Section 1 of the Act of 1921 expanded the application of the reverse onus to include any person who possessed or occupied a place (dwelling, store, boutique, warehouse, garden or ship) where drugs had been found. According to the wording of the section, that person was deemed to possess such a substance if he was unable to prove that it had been in that place without his consent or that he did not know that the drug was there.

---

[53] Statutes of Canada, 1925, c. 20

The article also provided that this procedure would apply when a person was charged with trafficking in raw or prepared opium for smoking purposes without having first obtained a permit issued by federal authorities. In 1923, the *Act to Prohibit the Improper Use of Opium and Other Drugs* (Act of 1923)[54] extended application of the reverse onus to offences involving the import or export of drugs without a permit. In cases involving the prescription or administration of a scheduled substance for non-therapeutic purposes, a physician or pharmacist had to prove that that substance had been used solely for medical purposes.

The Act of 1923 also cancelled another fundamental legal guarantee, the right of appeal. Section 25 eliminated the right of appeal in summary conviction cases involving possession, drug trafficking without a permit or for the sale, gift or distribution of a drug to a minor, the latter being an indictable offence. Section 26 of the Act of 1929 expanded this procedure to include possession of or trafficking in a substance similar to a drug. This new procedure rendered moot the provision enacted in 1911 prohibiting any application for a writ of *certiorari*, and the Narcotics Division sought its removal from the act, which was actually done in 1929.[55]

Two other important amendments were made to the *Opium and Narcotic Act* between 1920 and 1930 to provide for the admissibility of the certificate of a federal analyst and the application of the *Identification of Criminals Act* to summary conviction offences. Section 1 of the Act of 1921 had amended the legal procedure applicable in drug prosecutions by making the certificate of a federal analyst admissible in evidence with respect to one or more drugs seized by police officers. However, the courts were reluctant to accept the certificate because they could not authenticate the analyst's signature[56] or confirm his appointment. In 1929, an amendment was made to the *Opium and Narcotic Drug Act* (section 18) providing that the certificate would henceforth constitute *prima facie* evidence of the status of the person who gave or issued it. In this context, proof of that person's appointment or authentication of his signature was no longer necessary.

In 1923, the *Opium and Narcotic Drug Act* was amended to apply the provisions of the *Identification of Criminals Act* to persons convicted of an offence by way of summary conviction. Section 2 of that act permitted police officers to fingerprint, photograph and measure the accused solely in cases where they were indicted. That information constituted the accused's official "criminal record", which was kept in the national police records, with all the consequences that entailed for social, professional or family stigmatization. However, from the standpoint of the Narcotics Division, this amendment would prove beneficial since it would henceforth make it possible to establish files and more effectively monitor drug addicts convicted by way of summary conviction.

---

[54] *Statutes of Canada*, c. 22.

[55] P.J. Giffen *et al.*, *op. cit.*, page 261.

[56] *Ibid.*, pp. 278-279.

Control measures

The *Act to Amend the Opium and Narcotic Drug Act* (Act of 1920)[57] established a control system for the legal trade in narcotics through a system of permits issued to businesses, pharmacists and physicians by the Department of Health in order to regulate Canada's supply of drugs for medical or scientific purposes. The Act provided for: a prohibition against importing or exporting drugs at a port not designated for that purpose by federal authorities; the issue of permits for the import, export, manufacture, sale and distribution of drugs; the imposition of criteria regarding packaging and labelling of packages containing such substances; an obligation for businesses to keep a record of their drug importing, exporting, manufacturing, sale and distribution activities duly authorized by federal authorities; an obligation for physicians to provide the information requested by federal authorities concerning the purchase, manufacture or prescription of medications containing drugs; an obligation for pharmacists to keep a record of their purchases and sales of drugs, the preparation of their own medications containing such substances and renewals of prescriptions signed by a physician;[58] and the authorization to sell medications (such as ointments and liniments) containing very small quantifies of scheduled drugs without a permit, provided they were not administered to children under two years of age and met certain labelling criteria.

Amendments to the Act to Amend the Opium and Narcotic Drug Act in 1954

In 1954, Parliament passed the *Act to Amend the Opium and Narcotic Drug Act* (Act of 1954),[59] repealing offences relating to opium use and the possession of equipment intended for that purpose, the sale of drugs to a minor and drug trafficking through the mail. It also made two other significant amendments to the act.

Under the impetus of R.E. Curran, Deputy Minister of Health, it now included a definition of the offence of drug trafficking in order to make the act more comprehensible and increased the maximum prison term for that offence from seven to 14 years. The minimum prison term of six months and the fine were repealed. Henceforth, this offence could only be prosecuted by way of indictment. However, a person convicted of the offence was still liable to whipping and deportation.[60]

[57] *Statutes of Canada*, 1920, c. 31.

[58] This provision was added to the Act of 1911. In the years that followed, the criteria for renewing prescriptions issued by physicians were restricted so that the legal trade in narcotics could be monitored and drug addicts prevented from obtaining prescriptions and using the drugs thus obtained for trafficking purposes. For example, the Act of 1921 provided that a pharmacist could not fill or refill a prescription unless it had been signed by a physician. The Act of 1923 went further by prohibiting multiple refills of prescriptions of a drug based on the original prescription. The patient thus had to consult a doctor each time he wanted to renew.

[59] *Statutes of Canada*, 1954, c. 38.

[60] The provisions respecting the deportation of immigrants were transferred to the Immigration Act in 1952 but still applied to drug offences.

Subsection 4(3) of the Act of 1954 created the offence of possession for the purpose of trafficking, for which the new penalties provided for drug trafficking applied. This new offence would mean that those possessing large quantities of narcotic drugs would no longer be convicted for simple possession. As we have seen, a reverse onus was part of Canada's drug legislation from 1911 to 1929. In 1954, subsection 4(4) added a new criminal procedure to facilitate convictions for possession of drugs for the purpose of trafficking.

Thus, in every criminal prosecution for this offence, Crown prosecutors first had to prove that the accused was illegally in possession of the drug. The defendant then had to prove that he had not possessed the substance for the purpose of trafficking. If he succeeded, he was found guilty of possession; otherwise he was convicted of trafficking. In this specific case, Canadian courts established a distinction between the so-called secondary burden, which is to prove a specific fact (in this case the intention to traffic) and the primary burden (illegal possession), which consists in proving that fact where all the evidence is adduced. Thus the Crown prosecutor had the primary burden of establishing that an offence was indeed committed. In this particular case, however, the Crown did not have to prove that the accused intended to engage in trafficking. Proof of illegal possession was sufficient for the court to conclude that there was an intention to traffic.

This amendment was enacted in response to the recommendation by the RCMP and the Narcotics Office (former Narcotics Division) since, failing an admission by the accused, it was very difficult to prove the intention to traffic. However, this new procedure considerably undermined the rights of the accused, particularly since the act did not specify the quantity of drugs necessary to determine whether the accused had actually possessed it for the purpose of trafficking. The accused was thus guilty of trafficking in the absence of evidence to the contrary.[61]

Senate report of 1955

On February 24, 1955, the Senate passed a motion creating a Special Committee of the Senate on the Traffic in Narcotic Drugs in Canada following the motion made a few weeks earlier by Senator Thomas Reid. At that time, Senator Reid had asked the Senate government leader, W. Ross MacDonald, whether the federal government intended to create such a committee since, based on his information, the traffic in opium and other narcotics in the City of Vancouver was beyond the control of police authorities. In debate on the motion, Senator MacDonald accurately summed up the task before the members of the Senate Special Committee as follows:

> *The work of the committee will largely be to consider the causes of this unfortunate problem with which this country is faced, to hear expert witnesses and to determine in what way the Government can make*

[61] Giffen, P.J. *et al.*, *op. cit.*, pages 448-450.

its most valuable contribution in resolving this unfortunate condition. The reports of this committee, based upon an objective, cautious and factual assessment of the problem, may well become a document of the utmost importance and have far-reaching consequences in helping to found policy upon which the successful solution of this problem can rest. [62]

Upon adoption of the motion, Senator Reid was appointed chairman of the Committee. From March 25 to June 17, 1955, the committee organized public hearings in Ottawa and was the first to travel outside the capital, holding meetings in Montreal, Toronto and Vancouver. In addition to specialists, public servants and police officers, the senators also met a group of 150 people suffering from a drug dependency at Oakalla Prison in Vancouver to gain a better understanding of the reasons leading them to use drugs. The Committee heard 52 witnesses: 13 from law enforcement agencies, 10 from the various federal departments concerned by the fight against drug trafficking and 12 addiction treatment specialists. On June 23, 1955, Senator Reid tabled the Committee's report containing a series of recommendations for the treatment of people suffering from a drug dependency and the fight against the traffic in narcotic drugs.

According to the report, the figures provided by the Department of Health revealed that there were 515 "medical addicts" in Canada, that is to say individuals who had become dependent on a drug as a result of treatment for a disease, 333 "professional addicts" (doctors, pharmacists and so on) and 2,364 "criminal addicts", for a total of 3,212. Of the persons belonging to the last category, 1,101 were located in Vancouver.[63] Only 26 of the 2,364 "criminal addicts" were under 20 years of age.

To establish a relationship between crime and drug dependency and to explain the difficulties in establishing treatment programs, the Committee cited a study conducted by the RCMP noting that, of 2,009 "criminal addicts", 341 had first been convicted of an offence under the *Opium and Narcotic Drug Act*, 1,220 had first been convicted for other crimes and 478 had already had a criminal record. Thus, 1,668 of the total 2,009 "drug addicts" were criminals, which was sufficient in the Committee's view to confirm the thesis of the "criminal" or "contaminating" user.[64] It was therefore clear that drug addiction was not a disease. In the Committee's view, most "addicts" came from disadvantaged backgrounds in which crime and family problems were omnipresent.

The evidence of medical authorities was to the effect that drug addiction is not a disease in itself. It is a symptom or manifestation of character weaknesses or personality defects in the individual. The addict is usually an emotionally insecure and unstable person who derives support from narcotic drugs. The Committee was gravely concerned to learn that relatively few cases could be authenticated where drug addicts, while out of custody, had been successful in abstaining from the use of drugs for any lengthy

[62] *Hansard*, Senate, February 24, 1955, page 239.
[63] *Hansard*, Senate, June 23, 1955, page 739.
[64] *Hansard*, Senate, June 23, 1955, p. 739.

> *period of time. The complications and difficulties in the successful treatment of drug addiction, having regard to the pattern of development of the addict and his almost invariable criminal tendencies, cannot be too heavily stressed.*[65]

In the circumstances, the Committee unanimously rejected the idea of creating government clinics which, on certain conditions, would provide "criminal addicts" with ambulatory treatment. The Committee moreover emphasized that a resolution adopted at the time at the tenth annual session of the United Nations Narcotic Drug Commission, stated that this form of treatment was not advisable.[66] It also rejected the United Kingdom's model after confirming, with the aid of British specialists, that doctors should not encourage drug addicts to persist in their addiction if they could not, even after lengthy treatment involving gradual reduction of the prescribed doses abstain from drugs. On this point, the report states: "*[...] dangerous (narcotic) drugs in the United Kingdom are subject to a wide degree of control of the exacting standards demanded by the international agreements to which the United Kingdom, in common with Canada, is a party.*"[67]

Considering that "addicts" were "basically criminals who daily violate the *Opium and Narcotic Drug Act*", the Committee argued that municipal and police authorities, more particularly those of Vancouver, should more effectively invoke the provisions of the *Criminal Code* dealing with theft, vagrancy and prostitution. Citing the testimony of Harry J. Anslinger before a U.S. Congress committee, the Committee stated that such an initiative would solve much of the problem caused by drug addiction. Second, it noted that "*the evidence of many witnesses recommended the compulsory segregation and isolation of all addicts for long periods of time for the purpose of treatment and possible rehabilitation.*"[68]

Thus, to prevent this "scourge" from spreading in the penitentiaries and to cure "criminal addicts" convicted of crimes, the Committee suggested that "*the penitentiary authorities might give further consideration to the particular problems presented by criminal addicts in terms of segregation, treatment including specialized training and rehabilitation and other measures necessary in view of the special problems which addiction superimposes.*"[69] In fact, as Minister of Health, Paul Martin had done a year earlier, the Committee instead emphasized the limits of federal jurisdiction and the efforts the provinces should devote to the treatment of "drug addicts" who had not been convicted of a crime. Still advocating the segregation of these individuals, the Committee indicated that the federal government wanted to make available to British Columbia the federal William Head quarantine station on Vancouver Island so that it could transform it into a treatment centre similar to that in Lexington, Kentucky. It further proposed the creation of a national health program to provide financial support for provincial drug addiction initiatives.

---

[65] *Hansard*, Senate, June 23, 1955, p. 742.
[66] *Hansard*, Senate, June 23, 1955, p. 740.
[67] *Hansard*, Senate, June 23, 1955, p. 740.
[68] *Hansard*, Senate, June 23, 1955, p. 744.
[69] *Hansard*, Senate, June 23, 1955, p. 745.

The Committee also encouraged the creation of groups similar to Alcoholics Anonymous, but rejected the idea of national education campaigns for the general public and teenagers on the ground that "*such programs should not be used where they would arouse undue curiosity on the part of impressionable persons or those of tender years*".[70] The Committee supported the position of the UN Narcotic Drug Commission, recommending instead that a "mental health" program be established to detect behaviour in the schools that might lead to drug addiction.

Since treatment programs could not cure all "drug addicts", the Committee also proposed that certain measures be adopted to fight illegal trafficking in narcotics. It thus recommended:

- that a separate offence be created for the illegal importing/exporting of narcotic drugs in order to put an end to drug smuggling;
- that a maximum prison term be imposed of up to 25 years (life) for that new offence;
- that the maximum prison term be increased from 14 to 25 years for trafficking offences; and
- that it be possible to establish proof of a conspiracy in order to facilitate the conviction of the leaders of criminal organizations not directly involved in the sale of narcotics but which benefit therefrom.

In the Committee's view, the severity of these penalties would "*act as an effective deterrent to an individual in smuggling drugs into Canada for the profit of a 'higher up.'*"[71] Rather than waste police and court resources in trying to convict organized crime leaders who were the cause of the problem, an attempt had to be made to eliminate the "trafficker-distributors" in the neighbourhoods of the large cities and the problem would be solved.

Although the Committee's proposals were much more conservative than those advanced in the debates preceding its establishment, contrary to a number of other reports by parliamentary committees or royal commissions of inquiry, most of its recommendations would be followed by federal authorities. First, it contributed to a number of research projects in British Columbia and Ontario in 1956. And second, the Senate Committee's report was at the origin of most of the new provisions of the *Narcotic Control Act*, which was passed in 1961 to replace the *Opium and Narcotic Drug Act*.

[70] *Hansard*, Senate, June 23, 1955, page 741.
[71] *Hansard*, Senate, June 23, 1955, page 746.

FROM 1960 TO THE LE DAIN COMMISSION: THE SEARCH FOR REASONS

The period following World War II witnessed new attitudes toward narcotic drug control that would call into question the approach adopted by Canada since 1908 in fighting the abuse of and trafficking in narcotic drugs. The international human rights movement, the creation of organizations dedicated to the defence of civil liberties, the gradual democratization of access to universities, the appearance and development of new disciplines in the social sciences such as criminology, psychology, sociology, political science and the sociology of law, scientific progress and research into drug addiction were factors in the creation of new pressure groups consisting of more articulate individuals who disputed the use of criminal law as a "miracle" solution in responding to drug problems. However, it was not until the explosive increase in drug use in the 1960s, the hippie protest movement and the work of the Le Dain Commission that these demands materialized.

Narcotic Control Act (1961)

Passage of the *Narcotic Control Act* (Act of 1961)[72] coincided with the coming into force of the *Single Convention on Narcotic Drugs* of 1961, which played an important role in the creation of the modern international narcotic drug control system, an extension and expansion of the international legal infrastructure developed between 1909 and 1953. Work to group together the nine multilateral treaties signed during that period into a single international enactment began in 1948, and Canada played a significant role in the negotiations and drafting that led to its adoption.

While the Act retains most of the criminal procedures and offences established over the previous years, two amendments formed the subject of major parliamentary debate: the creation of an offence for illegal importing or exporting of narcotics and the increase in penalties for the offence of trafficking, and the treatment of drug addicts?. The minimum prison term of six months for simple possession was repealed, as was the procedure that provided that the *Identification of Criminals Act* would apply in the case of a summary conviction and the provision eliminating the right of appeal for certain offences.

The Act of 1961 was divided into two parts: the first, entitled "Offences and Enforcement", was placed under the authority of the Minister of Health, and the second, "Preventive Detention and Detention for Treatment", was to be administered by the Minister of Justice.

As the Senate Committee had recommended, section 5 of the Act of 1961 created the offence of importing and exporting narcotic drugs. Whoever was convicted of that offence (solely by way of indictment) was liable to a minimum prison term of seven years to a maximum of 25 years. That provision was designed to combat drug

---

[72] *Statutes of Canada*, 1961, c. 35.

smuggling between the United States and Canada and to comply with the international undertakings Canada had made in ratifying the Single Convention.[73]

In accordance with another recommendation from the Senate Committee report, section 4 of the Act of 1961 raised the maximum prison term for trafficking in narcotic drugs from 14 to 25 years. The provision for whipping was also repealed. These amendments also applied to the penalty provided for possession for the purposes of trafficking.

Part II of the Act, which comprised sections 15 to 19, defined the new federal policy regarding preventive detention and detention for treatment. First, the courts henceforth had the power to order that an individual convicted of trafficking, possession for the purpose of trafficking or importing/exporting drugs, and only if the accused had previously been convicted of similar offences, be placed in preventive detention for an indeterminate period of time. This measure replaced any other sentence which might have been imposed. Second, when a person was charged with simple possession, possession for the purpose of trafficking, trafficking or import/export, the court, at the request of Crown counsel or the accused, could order the accused detained for examination purposes to determine whether he was eligible for a drug addiction treatment program. If that was the case, the accused had to be sentenced to detention for treatment at a specialized federal institution for an indeterminate period of time in lieu of any other sentence provided for under the act. For a first offence, preventive detention could not exceed 10 years. The individual had a right of appeal, was subject to the *Parole Act* and could be referred to preventive detention at any time if he used drugs during his probation period.

Lastly, the Act of 1961 provided that, if a province adopted a preventive detention policy combined with a drug addiction treatment program (in cases not involving an offence under the act), the federal government could enter into an agreement with the competent authorities of that province to transfer drug addicts to the specialized federal institutions. These new provisions in fact enacted the Senate Committee's proposals.

Despite the intervention of two ministers, this treatment policy, based on a penal approach and, to a certain degree, oriented toward repression of the "contaminating user" or "criminal user", failed to stir up interest among parliamentarians. The measures were passed without opposition but, for reasons that remain unclear, were never proclaimed. The Le Dain Commission moreover questioned this decision by the federal government: *"Whether this is because of doubts about the constitutional validity of these provisions or the failure to develop suitable treatment methods and facilities or later reservations by the government as to the advisability of compulsory treatment in principle, or some combination of these, it's not clear."*[74]

---

[73] *Hansard*, House of Commons, June 7, 1961, page 6794.

[74] G. Le Dain *et al.*, *Cannabis: Report of the Commission of Inquiry into the Non-Medical Use of Drugs*. Ottawa: Government of Canada, page 221.

Another provision of the Act of 1961, but not the least, was passed by Parliament without debate: the schedule. The Single Convention of 1961 contained a series of schedules prepared by the World Health Organization containing the list of drugs subject to rigorous control for the purpose of preventing them from being used for other than medical or scientific purposes. Most were on the schedule to the Act of 1961, which now comprised more than 92 drugs and their derivatives, spread over 14 major classes (opium, cannabis, coca, phenypipedridine, and so on). No member of Parliament questioned the Minister of Health to determine the criteria or reasons advanced by his department for subjecting such a large number of substances to the restrictive provisions of the act.

An Act respecting Food and Drugs and Barbiturates *(1961)*

In the early 1960s, the use of drugs not included in the schedule to the *Opium and Narcotic Drug Act*, or, later, in the *Narcotic Control Act*, began to concern medical and government authorities. These drugs were barbituric acids or "goof balls", amphetamines, methamphetamines and the salts and derivatives of those three substances. These so-called psychotropic drugs could be used to reduce stress, eliminate insomnia, stimulate muscle and brain activity and eliminate appetite.

When physicians and other health professionals began to notice the number of barbiturate dependence cases and the serious secondary effects of those drugs in the 1950s, they asked the government to regulate their distribution and use more effectively. In addition, in 1957, following a Health Department survey of 2,500 pharmacies, more than 300 pharmacists were convicted for failing to comply with regulations respecting the prescription of barbiturates and amphetamines. This time, it should be pointed out, the position of health professionals had more influence on government authorities than the positions of police officers or the Narcotic Control Office. These substances were included in the *Food and Drugs Act* as "controlled drugs" and not in the *Narcotic Control Act*, for two reasons. First, certain harsh provisions of the Act of 1961 were coming under increasing criticism. Second, the use of those substances in a number of prescription medications meant that their use was widespread among the general public, particularly among persons holding good jobs, which ultimately was quite different from the unflattering picture hitherto painted of "drug addicts". In the circumstances, having recourse to the provisions of the Act of 1961 was out of the question.[75]

In 1961, Parliament thus passed the *Act to Amend the Food and Drugs Act* (Food and Drugs Act of 1961)[76] to better regulate the trade in barbiturates and amphetamines. The new act created Part III concerning the "controlled drugs" listed in Schedule G. It also created the offence of trafficking or possession for the purpose of trafficking, for

[75] P.J. Giffen *et al.*, *op. cit.*, pages 471-475.

[76] *Statutes of Canada*, 1961, c. 37.

which an accused was liable to a maximum prison term of 10 years, if convicted by way of indictment, or 18 months by summary conviction. However, simple possession of the substances was not illegal. Furthermore, unlike the *Narcotic Control Act*, the definition of trafficking excluded the distribution or giving of a controlled drug, but included the offences of importing and exporting.

In the case of criminal procedures applicable in a trial, a number of aspects were retained from the Act of 1961, such as the procedure concerning the reverse onus in a prosecution for possession for the purpose of trafficking, the use of a certificate from a federal analyst to confirm the nature of the drug, search and seizure writs of assistance, and the forfeiture and restitution of seized substances.

Lastly, Schedule G of the Act included three drugs: amphetamines, barbituric acids and methamphetamines, as well as the salts and derivatives of those drugs. During the debates, one member asked why other similar substances were not included in the schedule. The Minister of Health answered that, based on scientific research, only those three drugs were considered dangerous to human health.[77] Furthermore, as had been the case with the *Opium and Narcotic Drug* Act and the new *Narcotic Control Act*, the Governor in Council could make regulations upon recommendation by the Minister of Health, and where the public interest warranted it, to amend the schedule.[78]

Food and Drugs Act and hallucinogenics (1969)

In 1969, Parliament extended the application of legislative and bureaucratic controls to hallucinogenic drugs by passing the *Act to Amend the Food and Drugs Act* (Food and Drugs Act of 1969).[79] That enactment created Part IV, which was to govern the use of and trade in "restricted drugs" enumerated in the new Schedule J. Those drugs were lysergic acid diethylamide (LSD), N-Diethyltryptamine (DET) and Methyl-2,5-dimethoxyamphetamine (STP).

To better control the use of and trade in hallucinogenic drugs, the act provided for the same offences and procedures as those applying to barbiturates. It also created an offence of possession in order to deter anyone from using such drugs. In that instance, an accused was liable, on summary conviction, to a maximum prison term of three years and a fine of $5,000.[80] If found guilty of a first offence, on summary conviction, an accused was liable to a prison term of up to six months or a maximum fine of $1,000. For subsequent convictions, the act provided for a maximum prison term of one year or a fine of $2,000.

Narcotic Control Act and the offence of possession of cannabis

In the parliamentary debates on the Food and Drugs Act of 1969, the Minister of Health moved a very important amendment to the *Narcotic Control Act*. From 1921 until

[77] *Hansard*, House of Commons, May 30, 1961, page 5799.

[78] Subsection 37(2) of the *Food and Drugs Act, 1961*.

[79] *Statutes of Canada*, c. 41.

[80] Section 9 of the *Food and Drugs Act, 1969*.

the *Narcotic Control Act* was passed, Canadian legislation had provided for a hybrid offence in the case of simple possession of a drug. Since 1961, however, that offence was solely an indictable offence punishable by a prison term of up to seven years. The amendment proposed in 1969 maintained the offence, but again offered the option of proceeding by way of summary conviction, thus recreating a hybrid offence. In the case of a first offence in which an accused was found guilty on summary conviction, the Act provided for a maximum prison term of six months or a fine of up to $1,000, and a term of up to one year and a fine of $2,000 for subsequent offences. The amendment was considered necessary by the Minister of Health since the number of prosecutions for cannabis possession had increased from 493 in 1966 to 1,727 in 1969.[81] In his view

> *[...] in spite of the enormous variety of individual situations involved in that number of cases, the relevant section of that act provides very little scope for flexibility, either on the part of the Crown prosecutors or presiding judges or magistrates. There is no provision for the Crown to choose to proceed summarily. [...] This rigidity has been the subject of increasing criticism from a wide variety of sources such as the addiction research agencies of several provinces.*[82]

Lastly, the Food and Drugs Act of 1969 amended the procedure adopted in 1929 providing for the admissibility of a certificate from a federal analyst at trial for an offence involving a scheduled drug under the *Narcotic Control Act* or a Schedule G or J drug under the *Food and Drugs Act.* Crown prosecutors would henceforth be permitted to prove orally, under oath, by affidavit or solemn declaration, the status of the signatory of the certificate, who thus no longer had to appear in court. However, a judge could require the analyst to appear before him for examination or cross-examination to better assess the information contained in the affidavit or solemn declaration. The amendment was designed to ensure greater respect for the fundamental rights of the accused.

The Le Dain Commission (1969-1973)

When parliamentarians were examining the provisions of the *Food and Drugs Act* in 1969, they asked that a special committee be struck to look into the issue of drug use in Canada, particularly the use of cannabis. On May 29, 1969, the Liberal government headed by Pierre Elliott Trudeau passed Order-in-Council P.C. 1969-1112, establishing the Commission of Inquiry into the Non-Medical Use of Drugs, more commonly known as the Le Dain Commission. One of the reasons put forward to justify its creation was:

> *That notwithstanding these measures and the competent enforcement thereof by the R.C.M. Police and other enforcement bodies, the incidence of possession and use of these substances for non-medical purposes*

[81] *Hansard*, House of Commons, March 27, 1969, page 7203.
[82] *Hansard*, House of Commons, March 27, 1969, page 7203.

> *has increased and the need for an investigation as to the cause of such increasing use has become imperative.*[83]

The Commission's activities and reports

The Commission carried out its activities from mid-October 1969 until December 14, 1973, when its final report was tabled. During this period, it heard from 639 groups and individuals: 295 organizations presented briefs and 43 appeared before the members of the Commission; 212 individuals made submissions and 89 gave oral presentations. In total, the Commission held public hearings in 27 cities, including Ottawa and the ten provincial capitals, travelling some 50,000 miles around the country. During its term, the Commission published four reports: an interim report (1970), a special report on cannabis (1972), a report on treatment (1972) and a final report (1973). In addition to its Chairman, Gerald Le Dain, the Commission comprised four members: Ian L Campbell, Heinz Lehman, Peter Stein and Marie-Andrée Bertrand.

Before reviewing the Commission's recommendations in relation to cannabis, it is worthwhile to look into four aspects of the Commission's work that Dr. Marie-Andrée Bertrand brought up at a hearing of our Committee.

The first relates to the Commission's mandate, which was "extremely generous and broad." She presented it thus:

(a) to marshal from available sources, both in Canada and abroad, data and information comprising the present fund of knowledge concerning the non-medical use of sedative, stimulant, tranquillizing, hallucinogenic and other psycho tropic drugs and substances;

(b) to report on the current state of medical knowledge respecting the effect of the drugs...;

(c) to inquire into and report on the motivation underlying the non-medical use referred to in (a);

(d) to inquire into and report on the social, economic, educational and philosophical factors relating to the use for non-medical purposes... in particular, on the extent of the phenomenon, the social factors that have led to it, the age groups involved, and problems of communications; and

(e) to inquire into and recommend with respect to the ways or means by which the Federal Government can act, alone or in its relation with Government at other levels, in the reduction of the dimensions of the problems involved in such use.

> *Because the mandate was so broad, commissioners and the Commission's personnel got involved in a vast project which, in my opinion, had a great deal of impact on Canadian society. I am convinced that even though it had no influence at all on criminal legislation, the Le Dain Commission brought about a*

[83] Le Dain, G., *et al.*, (1973) *Canadian Government Commission of Inquiry into the Non-Medical Use of Drugs.* Ottawa: Government of Canada, page 4.

considerable change in the mentalities of Canadians, as it raised, for instance, awareness about the effects of traditional drugs.[84]

Second, the method used by the Commission to seek the opinions of Canadians. After mentioning the Commission's travel, she recalled that the public hearings gave the public an opportunity to ask questions and to confront the experts.

Thus, we raised a wide national debate on the factors whereby Canadian society … can, frequently resort to psychotropic substances to alleviate some of its suffering. In my opinion, the generosity of the mandate, the method of consultation, the style and attitude of the commissioners - and more specifically those of the Commission's chairman - brought about an effervescence of ideas about democracy, about how the State functions, and about the feeling of alienation that many Canadians felt and still feel vis-à-vis their national, provincial or municipal government.[85]

Third, the Commission's research mandate. Dr. Bertrand stated that the Le Dain Commission, at the height of its mandate, employed 100 persons, 30 of whom were full-time researchers. These researchers basically worked on four targets: (1) the effects of the drugs – and especially of cannabis, (2) drug use, (3) treatment problems, and (4) the influence of the media on the phenomenon.

Fourth, the Commission's impact. Dr. Bertrand believes that the democratic debate kicked off by the Commission had significant impact on knowledge about drugs. Many people came to understand that stereotypes of drug users as criminals were just that–stereotypes. The Commission also kicked off a deep debate about the factors pushing people to take drugs and increased awareness of these issues. What became apparent very quickly after the Commission started its work was Canadians' feeling of alienation from Canadian politicians and lawmakers, and the frustration that ordinary people are not listened to in this country.

The special report on cannabis

Before presenting their recommendations in connection with a new public policy on cannabis, the Commissioners made a number of observations about Canadian cannabis legislation.

- The decision to criminalize cannabis was made "*without any apparent scientific basis nor even any real sense of social urgency* […]".[86]
- The reversal of the evidentiary burden of proof for an offence of possession for the purpose of trafficking places a very heavy burden on the accused – significantly

[84] Dr. Marie-Andrée Bertrand, Professor Emeritus of Criminology, Université de Montréal, Evidence presented to the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-Seventh Parliament, 2001, page 45.

[85] *Ibid.*, page 46.

[86] Le Dain, G. *et al.*, (1972) *Cannabis: A Report of the Commission of Inquiry into the Non-Medical Use of Drugs*, Ottawa: Government of Canada, page 230.

weakening the principle of the presumption of innocence – since he must prove that he did not intend to traffic by a preponderance of evidence, not just by raising a reasonable doubt in the mind of the judge or jury.

- Law enforcement is made very difficult by the very nature of the offences that take place secretly and often on a consensual basis, and extraordinary methods of law enforcement must be used. However, "*the combined effect of their use in connection with [drug] laws has been one of the chief causes of concern about the impact of the criminal law in this field.*"[87]
- RCMP officers and officers in the provincial or municipal police services do not have the necessary financial, human or technical resources to curb narcotics trafficking as well as dealing with simple possession offences. All too often, possession cases are discovered accidentally in the course of other police investigations or surveillance activities over several months, resulting in a discriminatory application of the law.
- The decision as to whether to proceed by indictment or summary conviction varies considerably from one area to another of the country, and is influenced by the number of ongoing cases involving narcotics and the significant discretion exerted by crown attorneys. This inequitable application of the law can have extremely serious consequences on a defendant's future, particularly if a criminal record is the outcome.[88]
- Sentencing practices in drug cases are characterized by a wide disparity across Canada because of individual judges' perceptions about drug addiction, and their relative experience in criminal law and with cases involving simple possession or drug trafficking. According to the Commission's research, judges with greater experience in these types of cases handed down more lenient sentences. For example, sentences for simple possession involved fines or probation when a defendant did not have a criminal record, and, in trafficking cases, imprisonment of less than two years;[89] and
- From 1968 to 1971, the proportion of fines imposed for simple possession of cannabis increased from 1 % of all dispositions to more than 77 %.[90]

While the Commissioners agreed with these observations, their conclusions and recommendations were not unanimous.

The majority opinion – the recommendations of Gerald Le Dain, Heinz Lehman and Peter Stein

In order to explain the underlying reasons for their recommendations, the majority based their conclusions on the concept of harm, considering this the most

[87] *Ibid.*, page 239.
[88] *Ibid.*, page 245.
[89] *Ibid.*, pages 248-249.
[90] *Ibid.*, page 249.

useful criterion for laying down a new social policy for cannabis. This principle is associated both with the harm caused to an individual who uses a harmful substance, particularly his physical or mental health, and with the harm the individual causes to society, i.e. the impact on his family and colleagues. The concept of harm was of significance to the majority, since it made it possible to assess whether society should be concerned about the adverse effects of cannabis on human health and on society and, if such were the case, to what extent should criminal law apply in order to reduce those adverse effects. Should one criminalize simple possession of cannabis or only trafficking? Should measures such as decriminalisation or legalization be considered?

Initially, the majority wanted to eliminate some of the myths about the danger of cannabis:

> *The evidence of the potential for harm of cannabis is far from complete and far from conclusive. It is possible to find some fault with the methodology or the chain of reasoning in virtually all of the evidence. [...] On the whole, the physical and mental effects of cannabis, at the levels of use presently attained in North America, would appear to be much less serious than those which may result from excessive use of alcohol. However, there has not been sufficient experience with long-term, excessive use of cannabis under North American conditions to justify firm and final conclusions.* [91]

Regarding the amotivational syndrome, the Commission said it did not have conclusive data about personality change.

> *Some observers have spoken of apathy and a loss of goals, an absorption in the present with little or no thought for the future. All of these symptoms might be equally associated with a profound change of values and outlook which many might regard as salutary.*[92] *In our opinion, these concerns justify a social policy designed to discourage the use of cannabis as much as possible, particularly among adolescents.* [93]

The Commission did not have specific and conclusive scientific data to identify the harmful or beneficial effects of cannabis. On the other hand, while it believed that the dangers of cannabis (particularly those involving operation of a motor vehicle, poly-drug use, long-term mental deterioration and disorder, and criminality) were exaggerated, the Commission recognized that cannabis, like all other drugs, can have particularly harmful effects when it is used along with other drugs and that its use by adolescents could have a harmful effect on their maturation. The majority of members explained that, even if the use of cannabis is not a threat to the foundations of Canadian society or to our system of values based, for example, on a productive life, this element could not be excluded from the formulation of a new policy on cannabis.

---

[91] *Ibid.*, pages 266-267.
[92] *Ibid.*, page 270.
[93] *Ibid.*, page 274.

Secondly, since, in addition to health problems, cannabis use entails significant costs to the family, to society and to the economy, the majority justified the use of the criminal law, stating:

> *In our opinion, the state has a responsibility to restrict the availability of harmful substances-and in particular to prevent the exposure of the young to them-and that such restriction is a proper object of the criminal law [...] where, in its opinion, the potential for harm appears to call for such a policy.*[94]

For this reason, the majority rejected a public policy model based on legalization of the use and distribution. Even if legalization would have had the benefit of better controlling supply and quality, without a considerable increase in the number of long-term users, it could have led to some users moving on to hashish, with its higher concentration of THC, or encouraged users to smoke more marijuana or other cannabis products in order to obtain the desired psychoactive effect, and this would have cancelled out the effectiveness of control measures and increased the likelihood of abuse. [95]

Therefore, the majority recommended maintaining the offences of cannabis trafficking, of possession of cannabis for the purpose of trafficking, and importing and exporting cannabis. However, it adopted a much more liberal position with regard to controlling the demand:

> *The criminal law should not be used for the enforcement of morality without regard to potential for harm. [...] If we admit the right of society to use the criminal law to restrict the availability of harmful substances in order to protect individuals (particularly young people) and society from resultant harm, it does not necessarily follow hat the criminal law should be applied against the user as well as the distributor of such substances.*[96]

In this context, the majority felt it was necessary to amend the Narcotic Control Act, because "we do not believe that a change in the law need have an adverse effect on a proper appreciation of the caution with which we believe cannabis should be treated."[97] It was necessary to restore Canadians' confidence in and respect for the cannabis policy by reclassifying the drugs listed in the appendix to the Act, particularly cannabis. The majority opinion was based on the fact that:

> *While the Single Convention groups cannabis with the opiate narcotics it does not insist that it be given identical treatment in the law of the member states. The Single Convention has certainly been responsible for reinforcing the erroneous impression that cannabis is to be assimilated to the opiate narcotics but it does not prevent domestic legislation from correcting this impression. Because the present classification and legislative treatment of cannabis is so generally recognized to be erroneous and indefensible, any change in*

---

[94] *Ibid.*, page 281.
[95] *Ibid.*, pages 283-286.
[96] *Ibid.*, page 282.
[97] *Ibid.*, page 291.

it which corresponded more closely to the facts could be expected to command much more respect and careful attention [to the law].[98]

Restoring Canadians' confidence in the *Narcotic Control Act* also involved a comprehensive review of criminal penalties relating to cannabis. To justify this view, the majority pointed out that the harm caused by the criminal law, particularly on mere users, was more serious than the harm to their health and their environment caused by using the drug. In its analysis, the majority focussed on the consequences of sentences on young people, since over 85% of those convicted for cannabis possession or trafficking in 1970 and 1971 were under the age of 25.

A criminal record could have serious consequences for the future of young people, limiting the right to travel, and because of the family, social or professional stigma it caused. The majority were of the view that the possibility of obtaining a pardon is not sufficient to resolve this situation, since: *"the knowledge which a lot of people invariably possess of a conviction and the knowledge which can be obtained by interested parties through careful investigation cannot be eliminated."*[99] In fact, the *Criminal Records Act* provides only for removing information about the criminal record stored in national police files following a pardon, but not information in police investigation reports, or in legal documents stored in the law courts about the trial and the sentence, let alone newspaper articles.

Moreover, the majority of members deplored the extreme severity of sentences for cannabis use, stating, *"they are out of all proportion to the harm which could possibly be caused by cannabis. Moreover, they are excessive by comparison with those of most other nations."*[100] It disapproved of the maximum penalty of seven years' imprisonment for cannabis cultivation for one's own use, the mandatory minimum penalty of seven years' imprisonment for cannabis importing or exporting, as well as the possibility of life imprisonment for cannabis trafficking. The majority's criticism also covered the definition of trafficking, which included giving or offering, so that people who are merely passing a joint among friends in an evening could be charged with trafficking. The majority also mentioned that these sentences were made even more severe because:

- in the cases relating to possession of cannabis for the purpose of trafficking, the Crown could only proceed by way of indictment, with the consequence of more severe sentences; and
- the enforcement of the Narcotic Control Act was discriminatory (police investigations, the Crown Attorneys' discretion in deciding how to proceed, reversal of the burden of proof to the detriment of the accused, and judges' past experience).

---

[98] *Ibid.*, page 292.

[99] *Ibid.*, page 293.

[100] *Ibid.*, page 293.

The criminalization of cannabis had another negative effect: the illegal nature of simple possession and cultivation was conducive to the development of an illicit market, where some people must engage in crime or at least deal with criminals in order to obtain a supply. In some cases, people were exposed to other, more dangerous drugs. According to the majority:

> *Making cannabis legally available would not isolate people from contact with the illicit market in other drugs. From the point of view of influence, the important contacts are between drug users rather than between users and traffickers. Most users are initiated into new forms of drugs by other users. Interest in other drugs would not cease if cannabis were made legally available.* [101]

Finally, the use of extraordinary police powers, such as writs of assistance, often against users, only discredited the law further and adversely affected the morale of law enforcement authorities.[102]

For all these reasons, the majority recommended:

- that importing and exporting should be included in the definition of trafficking (as they are under the Food and Drugs Act), and they should not be subject to a mandatory minimum term of imprisonment;
- that it be possible to proceed by indictment or summary conviction in the case of trafficking and possession for the purpose of trafficking, and, on indictment, the penalty for this offence should be five years, and on summary conviction, eighteen months. It should be possible in either case to impose fine in lieu of imprisonment;
- that the prohibition against the simple possession of cannabis be repealed;
- that trafficking should not include the giving, without exchange of value, of a quantity of cannabis which could reasonably be consumed on a single occasion;
- that the prohibition against cultivating cannabis for personal use be repealed; and
- that the burden of proof on a person charged with possession for the purposes of trafficking be lightened, by stipulating in the Act that it is sufficient for the accused to raise a reasonable doubt as to his intention to traffic.

---

[101] *Ibid.*, page 296.
[102] *Ibid.*, pages 295-299.

Minority Opinion–the recommendations of Marie-Andrée Bertrand

According to Marie-Andrée Bertrand, Canada's cannabis policy required an in-depth reform that went far beyond merely amending the *Narcotic Control Act*. Dr. Bertrand took a much more liberal approach than the majority, and particularly Ian L. Campbell, as we will see below. Dr. Bertrand wrote that the Commission's research findings "*establish that a large number of people have used cannabis-more than a million in Canada. Very few of them have ever required medical or psychological treatment as a consequence. Smoking marijuana or hashish generally produces no serious personal problems, nor does it result in criminality.*"[103] Cases of habitual and excessive use were exceptional, as most users used cannabis recreationally. Any new public policy aiming at controlling cannabis use effectively without causing harm both to users and to society should consider these determinants. The use of the criminal law was out of the question. According to the Commissioner, there were several arguments in support of this conclusion.

Like the majority, she rejected a number of prejudices concerning harm caused by cannabis to human health, in particular its effects on brain activity and the ability to drive a vehicle, but recognized nevertheless that in large amounts cannabis could cause psychoses. While Marie-Andrée Bertrand commented that cannabis might have an effect on adolescent maturation, she said that very few facts supported the hypothesis put forward by the majority.[104] She also concluded that there was no relationship between cannabis use and criminality, aggression or the infamous amotivational syndrome.[105] Moreover, she rejected claims that cannabis use leads to poly-drug use in most users:

> *[...] a certain proportion of cannabis users take other drugs [...]. We are not dealing with a phenomenon that is limited to cannabis, LSD and the amphetamines (which are used in combination by only a few), but with an almost indiscriminate use of mood-changing substances in our society. When we include alcohol, it can be said that Canadians consume great quantities of a variety of psychoactive drugs, even if cannabis is excluded.*[106]

Second, users could not be sure of the quality of cannabis they bought, with all the concomitant repercussions, given the illicit and clandestine nature of production and distribution activities. Dr. Bertrand responded to the argument made by the majority that quality control of cannabis in a legal market would encourage a number of users to move to hashish by saying that no evidence points to such a possibility.[107]

Third, the prohibition of cannabis trade and illicit use was expensive and ineffective. Attempts to curb trafficking, despite all the efforts made by RCMP officers and municipal police forces, along with severe penal sanctions, were ineffective. The

[103] *Ibid.*, page 303.
[104] *Ibid.*, page 308.
[105] *Ibid.*, pages 307-309.
[106] *Ibid.*, page 308.
[107] *Ibid.*, page 309.

sentences provided for simple possession no longer had any dissuasive effect, since a million Canadians were using or had used cannabis.

Fourth, in its current form, the law had no educational or dissuasive impact, since Canadians' perception of the harm caused by cannabis was no longer the same as the government's. In this connection, Marie-Andrée Bertrand wrote:

> *A more important factor underlying problems in the application of the law is the gradual change in opinion taking place among Canadians regarding the harmfulness of this substance. The evidence has been taken into account - cannabis is not an opiate, its use does not induce physical dependence. The earlier opinions of society have been challenged and modified. [...] However, the continued prohibition of cannabis has precipitated, among many users, a generalized disrespect for the law.* [108]

For all these reasons, Marie-Andrée Bertrand recommended a "controlled legalization" policy for cannabis. She concluded that the federal government should remove cannabis from the *Narcotic Control Act* and initiate discussions with the provinces to have the sale and use of cannabis placed under controls similar to those governing the sale and use of alcohol. Such a system would entail regulations prohibiting the sale or distribution of cannabis to minors, and governing the distribution of a quality product at a price that would make smuggling impractical. To guarantee the success of the new approach, the federal and provincial governments were to work together in developing all stages of the production and distribution of cannabis, while undertaking multidisciplinary epidemiological research to evaluate the repercussions of a controlled legalization policy on health and human behaviour and to monitor patterns of use.[109]

Lastly, Marie-Andrée Bertrand considered that this policy would prove beneficial, not only for users, but also for the federal and provincial governments because of the considerable revenue they might well derive from the sales taxes on such a popular product.[110]

Minority Opinion–the recommendations of Ian Campbell

In comparison with the very liberal recommendations made by Marie-Andrée Bertrand, the recommendations by Ian Campbell were much more conservative in tone. Although he was in almost full agreement with the conclusions of the majority, he firmly believed that decriminalizing simple possession of cannabis would be misinterpreted by the media and by Canadians. If cannabis were legalized, the signal that would be sent out to society, particularly to young people, would be that cannabis is harmless, and might eventually lead to the accepted use of other, much more dangerous drugs. In this regard, he stated that, in both cases:

---

108 *Ibid.*, p. 304
109 *Ibid.*, pp. 310-311
110 *Ibid.*, p. 304

> *I think there is also a risk that the repeal of the prohibition on the possession of cannabis, even by the young, would be misunderstood as indicating a willingness by the society to condone and accept the use of the drug. There is little evidence to suggest that such a willingness exists. [...] The risk of such progression is probably not as great among those who have been deterred from use by the present law as among those who have already used cannabis. But the risk of progression is nonetheless real for some considerable number.*[111]

He also felt that maintaining the prohibition had a positive benefit–that of protecting young people from the harm caused by cannabis:

> *The potential for harm from adult use of cannabis is probably very much less than from use by the young. But, I find sufficient reasons to recommend the continuation of the general prohibition. Not the least of these reasons is the practical impossibility, at this time, of using the law to convey a perception of the dangers of cannabis without maintaining the prohibition for all, whether young or old.* [112]

Against this backdrop, the law was in the interest of prevention and morality, protecting as it did both individuals and society. Continuing in this vein, Mr. Campbell spoke about cannabis and young people's lack of maturity, saying:

> *We have properly been concerned about the damage done by placing too many duties and responsibilities on the individual too early. But it seems to me that recently we have been far too little concerned with the consequences of placing too many rights and freedoms on the shoulders of the young.* [113]

Despite it all, like other members of the Commission, Mr. Campbell recognized that some penal sanctions provided by the law could cause harm that was disproportionate in comparison with the real harm caused by cannabis on human health and society. He therefore recommended that the prohibition on the possession of cannabis be maintained, with possession of cannabis being punishable, upon summary conviction, by a fine of $25.00 for the first offence and a fine of $100.00 for any subsequent offence. Maintaining the prohibition would benefit not only users, but also police officers, since it:

> *Is entirely reasonable to assume that a high proportion of those currently arrested for possession as a result of systematic police investigation are in fact guilty of trafficking.* [114]

The work of the Le Dain Commission ended on December 14, 1973 when its final report was tabled. On July 31, 1972, John Munro, Minister of Health, revealed the policy that the federal government wanted to pursue following the tabling of the Commission's special report on cannabis. Even though he refused to legalize the use of

---

[111] *Ibid.*, page 311
[112] *Ibid.*, page 313
[113] *Ibid.*, page 314
[114] *Ibid.*, page 316

cannabis, the Minister stated his intention to remove cannabis from the *Narcotics Control Act* and place it under the *Food and Drugs Act*. This measure would be accompanied by lighter sentences for certain cannabis-related offences, research and education programs about its non-medical use, and less severe legal consequences for users. This measure would have covered hashish since the government *"wanted to make a clear distinction between this drug [cannabis] and dangerous narcotics like heroin."*[115] Two years later, on November 26, 1974, the federal government met its commitments by tabling Bill S-19 in the Senate.

Bill S-19 and cannabis

Bill S-19 created Part V of the *Food and Drugs Act* entitled "Cannabis". Thus, as recommended in the majority opinion expressed in the Le Dain Commission's special report, cannabis and cannabis users were no longer subject to the harsh provisions of the *Narcotic Control Act*.

Clause 7 of Bill S-19 defined "cannabis" as hashish, marijuana, cannabidol and THC. It continued the offence of possession, which, however, could only be prosecuted summarily. Anyone convicted of a first offence would be liable to a maximum fine of $5000 or, failing payment, to a maximum prison term of six months. For repeat offences, the fine would be fixed at an amount not exceeding $1,000 or, failing payment, a prison term not exceeding six months could be imposed. As may be seen, fines were favoured over imprisonment for simple possession.

The Bill also maintained the offences of trafficking, possession for the purposes of trafficking and cultivation of cannabis without a permit provided for by the *Narcotic Control Act*, punishable on summary conviction by a maximum fine of $1,000 or a prison term of up to 18 months or, if prosecuted by way of indictment, by a prison term of up to 10 years. The penalties provided were thus less severe than those provided for by the Act of 1961, except for the cultivation of cannabis. Although Bill S-19 created a dual-procedure offence for this crime, the maximum prison term was more severe (10 years rather than seven if prosecuted by way of indictment).

Lastly, a person convicted of importing or exporting cannabis was liable, on summary conviction, to a maximum prison term of two years or, if prosecuted by way of indictment, to a prison term of three to 14 years. Parliament thus wanted to show that cannabis trafficking and smuggling were crimes which it still considered very serious.

Apart from these offences, Bill S-19 also contained the criminal procedures included in Parts III and IV of the *Food and Drugs Act* (evidence of possession for the purpose of trafficking, certificate of the analyst, police powers and so on). Lastly, the provisions respecting regulations that the governor in council may make concerning the

---

[115] VALOIS, Donat, "La marijuana et le haschisch ne seront pas légalisés", *Le Droit*, Ottawa, August 1, 1972.

issuing of cultivation permits and possession of cannabis were now contained in the new Part V.

The Bill was considered by the Senate Standing Committee on Legal and Constitutional Affairs, which, in its report, recommended three amendments. The first added a provision for an exception to the *Criminal Records Act* so that any person receiving an absolute or conditional discharge would be automatically pardoned. The purpose of this measure was to eliminate the possibility that a criminal record might remain with the Canadian Police Information Centre (CPIC) following discharge. The second amendment increased the maximum prison term for trafficking in a narcotic from 10 to 14 years less a day. The third repealed the minimum term of three years for smuggling.

Bill S-19 was passed on third reading on June 15, 1975 and referred to the House of Commons, where it never passed second reading. In the fall of 1976, Mitchell Sharp stated in an interview that the bill would not be reintroduced since more important legislation was under consideration.

AFTER LE DAIN: FORGING AHEAD REGARDLESS

Throughout the 1970s, a number of federal politicians promised major reforms to lessen, even eliminate, the criminal penalties imposed on cannabis users. In 1972, the Liberal Party of Canada stated in its election platform that it intended to amend Canada's policy on marijuana,[116] which likely gave birth to Bill S-19. In 1978, Joe Clark, Leader of the Progressive Conservative Party, declared that a government formed by his political party would decriminalize possession of that drug.[117] However, promises of reform ceased in the early 1980s.

In the mid-1980s, Canadians witnessed a significant change in the federal government's position on drugs. This new situation was perhaps not unrelated to the U.S. policy of "war on drugs" adopted in the early 1980s by President Ronald Reagan. The United States once again became very active within international drug control agencies to encourage the international community to take energetic measures to put an end to drug trafficking, which "threatened American youth".

In 1987, Canada became actively involved in the work of the International Conference on Drug Abuse and Illicit Trafficking.[118] Two important events occurred at that meeting organized under the aegis of the United Nations. First, delegates passed a full multidisciplinary plan for future activities to combat drug abuse encouraging the

---

[116] Spicer, L. (2002) *Historical and Cultural Uses of Cannabis and the Canadian "Marijuana Clash"*. Ottawa: Parliamentary Research Branch, Library of Parliament.

[117] Giffen, P.J. *et al.*, (1991) *Panic and Indifference: The Politics of Canada's Drugs Laws.* Ottawa: Canadian Centre on Substance Abuse, page 571.

[118] Briefing notes, Research Office of the Progressive Conservative Party of Canada, June 1, 1987.

states to comply with their obligations under existing treaties. That initiative targeted four important areas: prevention and reduction of demand for illicit drugs, control of supply, suppression of illicit trafficking and treatment and rehabilitation. For the first time, international legal instruments made express provision for the reduction of supply. Second, delegates put the final touches on the treaty to suppress drug trafficking on a global scale. That treaty was passed in Vienna on December 20, 1988 as the *Convention on Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (Convention of 1988).

In addition to taking part in the work leading to the adoption of that convention, starting in the mid-1980s, Canada stepped up its international efforts with regard to drugs. In June 1987, it ratified the Convention on Psychotropic Substances of 1971[119] and promised to increase its financial participation in the United Nations Fund for Drug Abuse Control to $1 million by 1991. The Canadian government justified its participation in the international drug effort as follows:

> *"The Government is acting to stem the flow of drugs in and out of Canada, not only because Canadians are among the victims of drug abuse, but also because we have a role to play as responsible citizens of the world."*[120]

Canada was influenced by this international effort when, on September 13, 1988, before it had even signed or ratified the Convention of 1988 – which was not done until 1990 – Parliament passed Bill C-61, designed to combat laundering of the proceeds of crime (money laundering, enterprise crime, etc.). The Bill was aimed at organized crime and the financing of its operations through drug trafficking. The *Criminal Code* and the *Narcotic Control Act* were thus amended to create two new offences: laundering of proceeds of crime and possession of property obtained through drug trafficking. These new provisions also applied to the illegal activities of drug cultivation, trafficking and importing and exporting in or outside Canada if they were committed by Canadian citizens. Parliament did not need to legislate to criminalize the other activities prohibited by the Convention of 1988 since, as noted above, many had already been covered since 1961.

Controlled Drugs and Substances Act

In accordance with the commitment the federal government made in 1987, Minister of Health Perrin Beatty tabled Bill C-85, *An Act respecting psychotropic substances*, on June 11, 1992. It merged Parts III and IV of the *Food and Drugs Act* as well as the

---

[119] International Narcotics Control Board, *Report of the International Narcotics Control Board for 1987*, Vienna, United Nations Organization, 1988, p. 21.

[121] The tables of penalties in this section are reproduced from *Bill C-8: An Act to regulate certain drugs and other substances*, Legislative Summary 240, prepared by Allain, J., (1996; revised May 1997) Ottawa: Law and Government Division, Parliamentary Research Branch, Library of Parliament.

Narcotic Control Act into a single piece of legislation. Bill C-85 never passed report stage and died on the Order Paper in September 1993, when the 34th Parliament was dissolved.

On February 2, 1994, the new Minister of Health, Diane Marleau, retabled the legislation proposed by the former government under a different name, the *Controlled Drugs and Substances Act* (CDSA), which was passed by the House of Commons on October 30, 1995. After the first session of the 35th Parliament was prorogued, the bill was reintroduced in the Senate on March 6, 1996, and renumbered Bill C-8. The legislation went into effect on June 20, 1996.

This was the first major reform of Canada's drug legislation since the 1960s. Apart from the amendments made in 1988 under Bill C-61, the *Narcotic Control Act* had been amended in 1985 to abolish the writ of assistance and the procedure for establishing proof of possession of narcotics for the purpose of trafficking. In 1987, in *R. v. Smith*, the Supreme Court of Canada ruled that the minimum prison term of seven years for importing or exporting was unconstitutional under section 12 of the *Canadian Charter of Rights and Freedoms* (cruel or unusual punishment), as a result of which it was repealed.

One of the objects of the bill was to meet Canada's international obligations under the *Single Convention on Narcotic Drugs* (1961), the *Convention on Psychotropic Substances* (1971), and the *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (Vienna Convention, 1988).* It was further designed to introduce a legislative framework for regulating the import, production, export, distribution and use of scheduled substances under previous acts. The following sections describe the main provisions of this legislation.

Substances

The merger of the schedule of the *Narcotic Control Act* with those of the *Food and Drugs Acts* of 1961 and 1969, combined with the addition of new substances such as benzodiazepines and the precursors of this long list of substances, considerably increased the number of drugs subject to the restrictive provisions and procedures of the CDSA.

The expression "controlled substance" means a substance included in Schedule I, II, III, IV or V. In addition, the Act defines the term "analogue" as any substance that, in relation to a controlled substance, has a substantially similar chemical structure. Furthermore, anything that contains or has on it a controlled substance and that is used or intended or designed for use in producing or introducing the substance into the human body will be treated in the same way as that illegal substance.

- **Schedule I:** narcotic drugs such as opium, morphine and cocaine.
- **Schedule II:** cannabis, hashish, cannabinol, etc.

- **Schedule III**: stimulants such as amphetamines, hallucinogenics, such as mescaline, LSD and DET, and sedatives such as methaqualone, commonly called quaalude.
- **Schedule IV**: among others, anabolic steroids, hypnotics such as barbiturates and benzodiazepines (better known by their trademarks Seconal, Luminal, Valium and Librium).
- **Schedule V**: enumerates other substances that may be abused.
- **Schedule VI**: precursors, which produce no effects on the mind but can be converted or used to produce designer drugs, "simili-drugs" or substances contained in the schedules under Canada's international obligations under the *Single Convention on Narcotic* Drugs (1961) and the *Vienna Convention* of 1988.
- **Schedules VII and VIII:** concerning application of penalties for cannabis offences.

A total of more than 150 drugs, psychotropic substances and precursors now appear in the schedules of the act. It should be noted that section 60 of the CDSA continues the provision adopted in 1911 that the Governor in Council may, by order, amend any one of the schedules of the act by adding or deleting one or more substances where the Governor in Council deems the amendment to be necessary in the public interest.

Part I: Offences and Punishment

Participation in the aforementioned activities would not necessarily result in criminal penalties. As will be seen below, the act provides for regulations authorizing the possession, import and export and production for medical, scientific, industrial purposes or for the purposes of the act. Part I of the CDSA enumerates a number of types of offences:

(1) Possession of a Schedule I, II or III substance (subsection 4(1)); obtaining or seeking to obtain a Schedule I, II, III or IV substance, or the order necessary to obtain it from a practitioner (subsection 4(2)). The following table shows the maximum penalties for the offence of possession: [121]

Possession of a Schedule I Substance	
Indictable offence Summary conviction Reoffence	Seven years' imprisonment Fine of $1,000 or 6 months' imprisonment or both Fine of $2,000 or one year's imprisonment or both
Possession of a Schedule II Substance (cannabis in all its forms):	
Indictable offence Summary conviction Reoffence	Five years' imprisonment less a day Fine of $1,000 or 6 months' imprisonment or both Fine of $2,000 or one year's imprisonment or both
Possession of a Schedule VIII Offence (less than 1 g of cannabis resin (hashish) or less than 30 g of marijuana)	
Summary conviction only	Fine of $1,000 or 6 months' imprisonment or both
Possession of a Schedule III Substance	
Indictable offence Summary conviction Reoffence	3 years' imprisonment Fine of $1,000 or 6 months' imprisonment or both Fine of $2,000 or one year's imprisonment or both

The penalties imposed for the offence under subsection 4(2) are similar but slightly different from those provided for possession.

(2) Trafficking in a Schedule I, II, III or IV substance or any substance represented to be such a substance. Trafficking is defined as any transaction to sell, administer, give, transfer, transport, send or deliver a schedule substance, or to offer to do any one of those things. To "sell" means offering for sale, exposing for sale, having in one's possession for sale and distributing a substance, whether or not the distribution is made for consideration (subsection 5(1)); possessing any Schedule I, II, III or IV substance for the purpose of trafficking (subsection 5(2)). The following table shows the maximum penalties for these offences:

Trafficking in a Schedule I or Schedule II Substance (except in cases involving less than 3 kg of cannabis)	
Indictable offence No summary conviction offence	Life imprisonment
Trafficking in a Schedule III Substance	
Indictable offence Summary conviction	10 years' imprisonment 18 months' imprisonment
Trafficking in a Schedule IV Substance	
Indictable offence Summary conviction	Fine of $1,000 or 6 months' imprisonment or both One year's imprisonment

Trafficking in cannabis is not always punishable by the maximum penalty of life imprisonment. In cases of trafficking involving less than 3 kg of cannabis, a person is

guilty of an indictable offence and subject to a maximum term of five years' imprisonment less a day.

(3) Importing or exporting any Schedule I to VI substance (subsection 6(1)); having in one's possession any Schedule I to VI substance for the purpose of exporting it (subsection 6(2)). The following table shows the maximum penalties for these offences:

Importing or Exporting a Schedule I or II Substance	
Indictable offence No summary conviction	Life imprisonment
Importing or Exporting a Schedule III or IV Substance	
Indictable offence Summary conviction	10 years' imprisonment 18 months' imprisonment
Importing or Exporting a Schedule IV Substance	
Indictable offence Summary conviction	3 years' imprisonment One year's imprisonment

(4) Producing a Schedule I, II, III or IV substance. The expression "produce" is defined as meaning to obtain a substance by any method or process including manufacturing, synthesizing or using any means of altering the chemical or physical properties of the substance, or cultivating, propagating or harvesting the substance or any living thing from which the substance may be extracted or otherwise obtained. The following table shows the maximum penalties for this offence:

Producing a Schedule I or II Substance (other than cannabis/marijuana)	
Indictable offence No summary conviction	Life imprisonment
Producing cannabis (marijuana) (less than 1 g of cannabis resin (hashish) or less than 30 g of marijuana)	
Indictable offence No summary conviction	7 years' imprisonment
Producing a Schedule III Substance	
Indictable offence Summary conviction	10 years' imprisonment 18 months' imprisonment
Producing a Schedule IV Substance	
Indictable offence Summary conviction	3 years' imprisonment One year's imprisonment

(5) Possession of property obtained by crime (section 8) and offences relating to the laundering of proceeds of crime (section 9).

The penalties are obviously closely related to the schedule in which the substance in question appears. Furthermore, the penalties determined for cannabis offences also vary considerably depending on the quantity involved, a subject discussed in greater detail below.

Section 10 of the Act states the purpose of sentencing, which is to contribute to the respect for the law and the maintenance of a just, peaceful and safe society while encouraging rehabilitation, and treatment in appropriate circumstances, of offenders and acknowledging the harm done to victims and to the community. This section also provides a list of circumstances which the court is required to consider as "aggravating" factors in determining the sentence that shall be imposed on a person convicted of a designated substance offence. Those factors are: the use of a weapon or use of or threat to use violence, trafficking in a substance on or near school grounds or in or near any public place frequented by minors or by persons under the age of 18 years, and previous convictions of a designated substance offence. In addition, the use of the services of a minor in the commission of a designated substance offence is an aggravating factor. Any judge deciding not to sentence a person to imprisonment despite the presence of one or more aggravating factors is required to give reasons for that decision.

Part II: Enforcement

Sections 11 and 12 of the act concern search and seizure activities, which are discussed in greater detail in Chapter 14.

Section 13 incorporates certain *Criminal Code* provisions establishing a detailed plan for the return, reporting and detention of seized property. In the case of offence-related property, the *Criminal Code* provisions apply subject to sections 16 to 22 of the Act. Furthermore, a separate procedure is established under sections 24 to 29 to determine the disposal of controlled substances. It should be noted that section 14 provides for the issuing of a restraint order in respect of offence-related property.

Sections 16 and 17 concern the forfeiture of offence-related property. Offence-related property is defined as any property, within or outside Canada, by means of or in respect of which a designated substance offence is committed, that is used in any manner in connection with the commission of a designated substance offence, or that is intended for use for the purpose of committing a designated substance offence, but does not include a controlled substance or real property, other than real property built or significantly modified for the purpose of facilitating the commission of a designated substance offence. A court which convicts a person of a designated offence shall order the forfeiture of offence-related property where it is satisfied, on a balance of probabilities, that the property is offence-related property. Where the offence-related

property cannot be related to the offence with which the person is charged, the court may nevertheless order its forfeiture. The court may make such order where it is satisfied, beyond a reasonable doubt, that it is offence-related property. Furthermore, offence-related property may be forfeited even if legal proceedings were never instituted. The court shall render an order of forfeiture of property if it is satisfied (1) beyond a reasonable doubt that any property is offence-related property, and (2) that proceedings in respect of a designated substance offence in relation to the property were commenced, and (3) that the accused charged with the offence has died or absconded.

Sections 18 to 22 are essentially a restatement of sections 462.4 to 462.45 of the *Criminal Code*. The purpose of these provisions is to protect the interests of innocent third parties and good-faith buyers. As a general rule, if the court is satisfied that the claim is lawful, it may order the return of the property (or payment of its value if restitution is impossible) to the person who is its legitimate owner or who is entitled to own it.

Section 23 merely incorporates the *Criminal Code* provisions on forfeiture of proceeds of crime. The same terms and conditions are thus established in the case of the forfeiture of the proceeds of designated offences.

Part III – Disposal of Controlled Substances

Under subsection 13(4) of the Act, where a controlled substance has been seized, a report identifying the place searched, the substance seized and the location where it is being detained shall be filed with the justice of the peace of the territorial division concerned. Sections 24 to 29 of the Act govern the disposal of controlled substances.

Section 24 establishes the pre-trial procedure for the return of controlled substances. For example, any person may, within 60 days after the date of the seizure, finding or acquisition by a peace officer or inspector, apply to a justice of the peace for a restitution order. If the justice is satisfied that the application is valid, he shall order that the substance be returned to the applicant. In the opposite case, the justice orders forfeiture to the Crown. The substance is then disposed of in accordance with the applicable regulations or as the Minister directs. Where no application for return is made, the substance is delivered to the Minister and disposed of in accordance with the applicable regulations or, failing such regulations, in such manner as the Minister directs.

It should be noted that section 26 enables the Minister to ask the justice of the peace to order that a controlled substance be forfeited, at any time, if he has reasonable grounds to believe that it constitutes a potential security, public health or safety hazard. The application is essentially made *ex parte*. If the justice of the peace finds that the Minister has reasonable grounds to believe that the substance constitutes a potential security, public health or safety hazard, he orders its forfeiture. The substance is then disposed of in accordance with the applicable regulations or, if there are no applicable regulations, in such a manner as the Minister directs.

Section 27 regulates the post-trial procedure for returning controlled substances seized–the persons whose substances were seized is entitled to have them returned where the court rules his activities legitimate. Otherwise, the substance is returned to the true legitimate owner, provided that that person can be identified. If neither is possible, the substance is forfeited to the Crown, which disposes of it in accordance with the applicable regulations or, if there are no applicable regulations, in such manner as the Minister directs.

Section 28 enables the Minister to dispose of a controlled substance with the owner's consent.

Lastly, under section 29, the Minister may destroy any plants from which a Schedule I, II, III or IV substance may be extracted and that is being produced without a regulatory licence or in violation thereof.

Part IV – Administration and Compliance

This part concerns the powers assigned to inspectors to ensure that holders of a regulatory authorization or licence to deal in controlled substances or precursors are complying with the regulations.

The inspector may, at any reasonable time, enter any place he believes on reasonable grounds is used for the purpose of conducting that person's business or professional practice. The Act authorizes inspectors to conduct a series of inspection acts, including seizing and holding any controlled substance or precursor which he deems on reasonable grounds must be seized or held. The Act makes provision for the return of seized property. It should be noted that, in the case of dwelling-places, the inspector must first obtain the occupant's consent or hold a warrant.

Part V – Administrative Orders for Contraventions of Designated Regulations

This part makes provision for the administrative procedure that is to be followed where a regulation designated by the Governor in Council has been contravened. Under section 33 of the CSDA, the Governor in Council may proclaim certain regulations made under section 55 as "special regulations". Non-compliance with those regulations may result in administrative orders providing for severe penalties, including revocation of the permit or licence issued by the Minister of Health (subsection 40(4)).

Part VI – General

Sections 44 to 60 are general provisions. For example, sections 44, 45 and 51 concern the designation of analysts, the scope of their duties and the admissibility of their reports at trial.

Section 46 creates a general penalty applying to anyone who contravenes a provision of the Act for which no penalty is specifically provided or contravenes a regulation. An indictable offence is punishable by a maximum fine of $5,000 and/or three years' imprisonment. An offence punishable on summary conviction results in a $1,000 fine and/or six months' imprisonment.

Under section 47, summary convictions for certain offences under the act and regulations must be commenced within one year of the commission of the offence. All other summary procedures must be commenced within six months of the offence.

Other sections concern the following matters: that the prosecutor is not required, except by way of rebuttal, to prove that a certificate, licence, permit or other qualification does not operate in favour of the accused (section 48); that a copy of any document filed with a department is admissible in evidence without proof of the signature of the authority (section 49); that a certificate issued to a police officer exempting him from the act or its regulations is admissible in evidence at trial and, in the absence of evidence to the contrary, is proof that the certificate or other document was validly issued, without proof of the signature or official character of the person purporting to have certified it, although the defence may, with leave of the court, cross-examine the person who issued the certificate (section 50); that the giving of any document may be proved by oral evidence, affidavit or solemn declaration, even though the court may require the signatory to appear (section 52); that the continuity of possession of any exhibit tendered as evidence in a proceeding may be proved by the testimony, affidavit or solemn declaration of the person claiming to have had it in his possession (section 53); and that certified copies of records, books, electronic data or other documents seized may be presented as admissible evidence by the Minister's officer, the copied versions having the same probative force as the originals, unless the accused submits evidence to the contrary (section 54).

Subsection 55(1) establishes the power of the Governor in Council to make regulations. One of the objectives of Canada's drug policy was to monitor the legal trade in scheduled drugs for medical or scientific purposes. The CSDA significantly enhanced the Governor in Council's power to make regulations with respect to designated substances and precursors. The regulations made under the CSDA apply in particular to businesses, physicians and pharmacists. The Governor in Council may thus make regulations, with respect to the designated substances or precursors:

- Governing, controlling, limiting, authorizing the importation and exportation, production, packaging, sending, transportation, delivery, sale, administration, possession or obtaining of those substances or precursors;
- Issuing permits to businesses or persons permitting the aforementioned activities, defining the terms and conditions of payment and their revocation, and determining the qualifications required of permit holders;
- Controlling the methods of production, storing, packaging and restricting the advertising, if necessary, for the sale of those substances;
- Governing the books, records, electronic data or other documents that must be established by the businesses, physicians or pharmacists or any other permit holder engaged in the activities enumerated in the first point;
- Authorizing, if necessary, the communication of information obtained through investigations conducted by the inspectors of the Department of Health to provincial authorities in respect of a serious contravention of the regulations

concerning the activities defined in the first point so that they may take disciplinary measures;

- Exempting, on conditions set out in the regulations, any person or class of persons from the application of section 55.

Under subsection 55(2), the Governor in Council, on the recommendation of the Solicitor General of Canada, may make regulations that pertain to investigations and other law enforcement activities. This includes regulations exempting police officers, in certain circumstances, from the application of Part I of the Act (Offences and Penalties).

Under section 56, the Minister may, on such terms and conditions as the Minister deems necessary, exempt any person or class of persons or any controlled substance or precursor or any class thereof from the application of all or any of the provisions of the act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest. Section 57 concerns the delegation of the powers of the Minister and the Solicitor General.

Section 58 provides that the provisions of the act and the regulations made under it prevail over any incompatible provisions of the *Food and Drugs Act* or its regulations.

Section 59 makes it an offence to make or assent to the making of a false or misleading statement in any book, record, return or other document that must be made under the act or regulations.

As mentioned, under section 60, the Governor in Council may amend any schedule to add or delete a controlled substance.

The specific case of cannabis

In the first version of the CSDA, cannabis was cited in the schedule containing the most dangerous drugs to which the most severe criminal penalties described above applied. To allay criticism, the government agreed to withdraw cannabis from Schedule I and created Schedules II, VII and VIII, which concern that drug exclusively. Schedule II defines cannabis as marijuana, cannabis resin (hashish) cannabinol, and so on. Schedule VII established at three kilograms of cannabis or hashish the maximum quantity for the imposition of a less severe penalty for trafficking or possession for the purpose of trafficking in that substance. Lastly, Schedule VIII provided that a person who had less than one gram of hashish or less than 30 grams of cannabis in his possession for his own personal use was liable to less severe criminal penalties than those provided for in Schedule II.

As a result, if a person is convicted of possession, possession for the purpose of trafficking or possession of a quantity greater than that defined in Schedules VII and VIII, the more severe penalties provided for in Part I for Schedule I or II substances apply. Otherwise, the CSDA defines new criminal penalties. As regards Schedule VIII, section 4 of the CSDA provides that a person charged with simple possession of cannabis may be prosecuted summarily and provides for a maximum term of

six months' imprisonment, a maximum fine of $1,000 or both. Contrary to the majority recommendation made in the 1972 special report of the Le Dain Commission respecting the reduction of the penalty imposed for importing and exporting cannabis, life imprisonment still applies. Lastly, the maximum prison term of seven years provided for by the *Narcotic Control Act* for the offence of cultivation (production) of that drug remains unchanged under the CSDA.

CONCLUSIONS

Conclusions of Chapter 12

- **Early drug legislation was largely based largely on a moral panic, racist sentiment and a notorious absence of debate.**
- **Drug legislation often contained particularly severe provisions, such as reverse onus and cruel and unusual sentences.**
- **The work of the Le Dain Commission laid the foundation for a more rational approach to illegal drug policy by attempting to rely on research data.**
- **The Le Dain Commission's work had no legislative outcome, except in 1996, in certain provisions of the Controlled Drugs and Substances Act, particularly with regard to cannabis.**
- **No action was taken on the reform proposals introduced in the 1970s, particularly for the decriminalization of cannabis.**
- **Thirty years after the Le Dain Commission, the legislation and its application have had no notable effect on the supply and demand of cannabis.**
- **The present act Act takes no account of data from research on the comparative effects of various substances, particularly the effects of cannabis.**

CHAPTER 13

REGULATING THERAPEUTIC USE OF CANNABIS

As discussed in Chapter 9, cannabis has an extremely long history of therapeutic use, going back several thousands of years. It was often used for the same medical conditions it is used for today. With the development of the pharmaceutical industry in the last century, the medical community has gradually discontinued its use. Various factors may explain this. Developments in the pharmaceutical industry provided the medical community with more stable and better tested medication. The practice of medicine itself has changed and so has our conception of health. Then, at the turn of the 20th century, the plants from which opium, cocaine and cannabis are derived were banned by the international community, except for medical and scientific purposes. In the case of cannabis, no rigorous study had been done, until recently.

Further to the social rediscovery of cannabis and the identification of its molecular composition and chemical elements in the 1960s, renewed interest in the therapeutic applications of cannabis grew in the early 1970s. More people began using the plant for its therapeutic benefits and many demanded a relaxation of the prohibitionist rules governing cannabis.

Because its safety and effectiveness have yet to be reviewed in clinical trials, cannabis has not been approved for sale in Canada as a medical product.[1] Despite this lack of approval, many use cannabis for its therapeutic purposes without legal authorization. In addition, because of the many claims regarding its therapeutic benefit, a growing number of people have called for a less restrictive approach and are demanding access to cannabis for people who could benefit from its use.

This chapter reviews the events that prompted the recent enactment of the *Marihuana Medical Access Regulations.* One of the objectives of the regulations is to provide a compassionate framework of access to marijuana for seriously ill Canadians while research regarding its therapeutic application continues. Also discussed is the implementation of these regulations, which came into force on 30 July 2001.

[1] Two commercially available drugs related to cannabis have been approved for sale in Canada: Marinol, which contains chemically synthesized THC; and Cesamet, a synthetic cannaboid. Both may be prescribed by physicians.

BACKGROUND TO THE RECENT REGULATIONS

Section 56 – Controlled Drugs and Substances Act

The *Controlled Drugs and Substances Act*[2] (CDSA) prohibits a series of activities relating to psychoactive substances, including: possession; cultivation; trafficking; possession for the purposes of trafficking; importation; and exportation. These activities are illegal unless authorized by regulations made under the CDSA. For example, the *Narcotic Control Regulations* regulate the legal distribution of narcotic drugs.[3] In addition, before a drug may be marketed in Canada, it must be approved for sale under the *Food and Drugs Act*[4] (FDA) and its regulations. The regulations under that Act set out controls dealing with, among others, the safety, efficacy and quality of therapeutic products. To market marijuana as a drug in Canada, a sponsor would have to file a "New Drug Submission" with the Therapeutic Products Programme of Health Canada. Submitted data would be evaluated to assess the potential benefits and risks of the drug before the drug would be approved for sale.

Other mechanisms authorize certain otherwise prohibited activities. Pursuant to section 56 of the CDSA, the Minister of Health is authorized to grant exemptions if, in his or her opinion, such an exemption is necessary for a medical or scientific purpose or is otherwise in the public interest. Thus, any person or class of persons may be exempted from the application of all or any of the provisions of the CDSA in these specified circumstances. These circumstances include both the cultivation and possession of marijuana, activities that are otherwise prohibited by the legislation.

In response to the growing demand for access to cannabis for therapeutic purposes and to Charter challenges in relation to therapeutic use, Health Canada published an Interim Guidance Document in May 1999. This document set out a process enabling Canadians to apply for an exemption to possess and cultivate marijuana for therapeutic purposes under the authority provided in section 56 of the CDSA. Applicants were required to demonstrate that the exemption was necessary for such purposes and required a statement from a physician in support of the application, along with details of their medical and drug therapy histories. Health Canada reviewed the applications on a case-by-case basis, taking into account the medical necessity of the applicant. The first exemption was issued in June 1999. As of 3 May 2002, 658 exemptions had been granted under the authority of section 56, and 501 were still active. With respect to the other 157 persons with exemptions, some are now authorized to possess the substance under the recently enacted *Marihuana Medical Access Regulations* and others may no longer need marijuana for therapeutic purposes. Under

---

[2] S.C. 1996, Chapter 19.

[3] These drugs are set out in the schedule and include opium, codeine, morphine, heroin, cocaine, and cannabis.

[4] R.S.C. 1985, Chapter F-27.

this process, persons with exemptions were required to limit their cultivation to the quantity specified in their exemption letter.[5]

In February 2000, as part of a commitment to public consultation in relation to the section 56 exemption program, a multi-stakeholder consultation workshop was held. The participants[6] identified the following issues as priorities:

- Obtaining a legal source of marijuana for persons exempted under section 56;
- Exemptions for caregivers;
- Addressing the need for more information on the use of marijuana for medical purposes;
- Addressing concerns of law enforcement agencies;
- Improvement of the process and tools for section 56 applications; and
- Communications regarding the section 56 process and Health Canada's activities regarding marijuana for medical purposes.[7]

The information gathered at these consultations was later used for the development of the *Marihuana Medical Access Regulations.*

Charter challenges – therapeutic use of marijuana[8]

Charter challenges to prohibitions with respect to marijuana by those using the substance for therapeutic purposes have met with some success. In *Wakeford v. Canada* (1998),[9] a person suffering from AIDS and using marijuana to fight nausea and loss of appetite, which were side-effects of the drugs he was taking to fight AIDS, sought a constitutional exemption from the prohibitions with respect to marijuana in the CDSA. The Ontario Court, General Division, found that by denying the individual the autonomy to choose how to treat his illness, the law infringed his rights to liberty and security of the person under the Charter. The Court indicated that the prohibition on marijuana was not arbitrary inasmuch as there is some risk of harm associated with its use.[10] Thus, the Court found that in its general application, the law was consistent with

---

[5] In June 1999, Health Canada released a report announcing a research plan for the use of marijuana for therapeutic purposes and stating that steps would be taken to establish a domestic source of research-grade marijuana. Both of these initiatives are discussed in more detail in subsequent sections of this chapter.

[6] Participants included representatives from law enforcement, practicing physicians, research clinicians, National Association of Pharmacy Regulatory Authorities, Health Canada and others of unknown affiliation.

[7] Regulatory Impact Analysis Statement accompanying the *Marihuana Medical Access Regulations*, p. 17.

[8] This section is based largely on *Drug Prohibition and the Constitution*, a paper prepared for the Senate Special Committee on Illegal Drugs, by David Goetz, Law and Government Division, Parliamentary Research Branch, Library of Parliament, 1 March 2001.

[9] [1998] O.J. No. 3522 (Ont. Gen. Div.).

[10] *Ibid.*, at paras. 49-50.

the principles of fundamental justice as set out in section 7 of the Charter. However, the law's impact on medical users raised additional considerations. As applied to these users, the blanket prohibition is over-broad and does not support the state's rationale for prohibition.

The Court held that it would be contrary to the principles of fundamental justice to prohibit the use of marijuana where it can be shown to be a significant medical treatment for a debilitating and deadly disease and where there was no procedural process for obtaining an exemption from prosecution.[11] However, the Court noted that such a process was provided for in section 56 of the CDSA. Therefore, the Court found that the law was in accordance with fundamental justice – even in respect of medical users – and denied Mr. Wakeford a constitutional exemption. It emphasized that, without a ministerial exemption process for medical users, the case would have been decided differently.[12] Later, Mr. Wakeford was granted an interim constitutional exemption with respect to the offences of possession and production/cultivation of marijuana on the basis of "fresh evidence" indicating that no real process had been established to deal with applications for exemptions under section 56 of the CDSA. Because the statutory exemption turned out to be "illusory," the Court reopened the case and granted the exemption. It would remain in effect until the Minister of Health had made a decision on Mr. Wakeford's application for an exemption under section 56 of the CDSA.[13]

In *R. v. Parker* (2000),[14] the Ontario Court of Appeal reached a similar conclusion with respect to the impact of the blanket prohibition on marijuana use on the "liberty and security of the person" interests of medical users. In *Parker*, the accused–who had been charged with cultivation and possession of marijuana–grew and used marijuana to control his epileptic seizures. The Court held that the criminal prohibition on the use of marijuana, vis-à-vis *bona fide* medical users, engaged their section 7 right to liberty because of the possibility of imprisonment. In addition, by depriving such individuals of the ability to choose marijuana as medication to alleviate the effects of a serious illness, the prohibition also infringed their rights to liberty and security of the person, independent of the potential for imprisonment. The Court in *Parker* further concluded that the blanket prohibition on marijuana possession did not accord with the principles of fundamental justice. The Court of Appeal made reference to the findings of the trial judge with respect to the medical conditions and symptoms for which cannabis has a therapeutic effect:

> *Based on the evidence adduced at trial, the trial judge found that the defence had established that smoking marihuana has a therapeutic effect in the treatment of nausea and vomiting particularly related*

[11] *Ibid.*, at para. 54.
[12] *Ibid.*, at para. 66.
[13] [1999] O.J. No. 1574, at paras. 11, 31 and 32.
[14] 49 O.R. (3d) 481.

> *to chemotherapy, intraocular pressure from glaucoma, muscle spasticity from spinal cord injuries or multiple sclerosis, migraine headaches, epileptic seizures and chronic pain.*[15]

Of significance to this chapter, the Court in *Parker* concluded that the exceptions and exemptions contemplated by the legislation that could cover approved medical use were contrary to the principles of fundamental justice. Firstly, although the legislation theoretically contemplated that a person could obtain marijuana with a doctor's prescription, the evidence in the case established that no pharmacist would fill such a prescription; the government would not look favourably on any physician who prescribed marijuana; and it was practically impossible to find a legal source of marijuana in Canada.[16] Thus, this exception to the prohibition was held by the Court to be illusory.[17]

Secondly, with respect to ministerial exemptions under section 56 of the CDSA, the Court found this procedure to be inadequate and not in accordance with the principles of fundamental justice. The Court ruled that, under section 56, unfettered discretion was vested in the Minister of Health, an inappropriate basis for decisions relating to the security or liberty of the person in the context of access to medical treatment to alleviate the effects of serious illness.[18] Key issues relating to the section 56 exemption process included: the broad discretion given to the Minister under the CDSA; transparency of the process; and a clear definition of medical necessity.

In the end, the Court concluded that the broad prohibition on possession of marijuana was contrary to section 7 of the Charter and did not constitute a reasonable and justified limit under section 1 of the Charter.[19] The Court then declared the prohibition on the possession of marijuana to be unconstitutional and of no force and effect. However, the Court suspended the declaration of invalidity for one year in order to give Parliament the opportunity to amend the law to include adequate exemptions for medical use. In the interim, Mr. Parker was granted a personal exemption from the prohibition on possession of marijuana. The Court in *Parker* suggested its finding that the prohibition on possession of marijuana violated section 7 of the Charter would likely apply to the prohibition on cultivation as well.[20]

Government reaction

In September 2000, while an appeal was still under consideration, the government announced its intention to establish a new regulatory approach, which would define the circumstances and the manner in which the use of marijuana for therapeutic purposes

---

[15] *Ibid.*
[16] *Ibid.*, at para. 155.
[17] *Ibid.*, at para. 163.
[18] *Ibid.*, at paras. 184-185 and 188.
[19] *Ibid.*, at paras. 191-194.
[20] *Ibid.*, at para. 190.

would be authorized.[21] A *Notice of Intent* was published on 6 January 2001 and meetings were held with key stakeholders as identified by Health Canada.[22]

In April 2001, the government unveiled proposed regulations governing the possession and production of marijuana for therapeutic purposes. The proposed regulations were designed to address the key issues raised by the Ontario Court of Appeal in relation to the section 56 exemption process. There were two parts to the draft regulations: (1) authorization to possess and (2) licence to produce.

The 30-day regulatory consultation period, during which Health Canada received comments from 139 individuals and groups, resulted in the following changes being made to the proposed regulations: the application process would be managed by the individual applicant instead of by a medical practitioner; restrictions on growing locations would be relaxed and would no longer include a one-kilometre restriction on cultivation outdoors near schools and other places frequented by children; the formula to calculate the number of plants permitted under a licence to produce would be adjusted to reflect estimated indoor and outdoor growing yields and margins of error; and transitional provisions would be included to extend all current exemptions by six months with the objective of ensuring patients would be afforded ample opportunity to comply with the new regulations.[23]

On 4 July 2001, the government announced that the regulations governing the possession and production of marijuana for therapeutic purposes would come into effect on 30 July 2001.

MARIHUANA MEDICAL ACCESS REGULATIONS

As stated above, there are two parts to the *Marihuana Medical Access Regulations* (MMAR): part 1, authorization to possess, and part 2, licence to produce. One of the objectives of the regulations is to provide a compassionate framework to allow access to marijuana for medical purposes.

> *The regulations establish a compassionate framework to allow the use of marijuana by people who are suffering from serious illnesses, where conventional treatments are inappropriate or are not providing*

---

[21] Health Canada, News Release, *Minister Rock announces intention to develop new approach for the use of marihuana for medical purposes*, 14 September 2000.

[22] Key stakeholders included representatives from the Canadian Medical Association, the Canadian Pharmacists Association, the Canadian AIDS Society, the RCMP, Solicitor General Canada, Department of Justice, Correctional Service Canada and the Canadian Association of Chiefs of Police.

[23] Health Canada, Information, *Marijuana Medical Access Regulations – Amendments Resulting from Public Consultations*, July 2001.

adequate relief of the symptoms related to the medical condition or its treatment, and where the use of marijuana is expected to have some medical benefit that outweighs the risk of its use.[24]

As will be reviewed in detail, the MMAR are intended to provide access to marijuana in special circumstances only: in the case of serious medical conditions where conventional treatment may not provide adequate symptomatic relief. Health Canada explains that this limitation is due to *"the health risks associated with the smoked form in particular, and due to the lack of evidence supporting the claimed health benefits."*[25]

Significantly, the application of the MMAR is limited to "Cannabis (marihuana)" as referred to in sub-item 1(2) of Schedule II of the CDSA. Thus, the regulations do not provide access to other cannabis-related products.

The key provisions of the MMAR are as follows.

Authorization to possess

Three distinct categories have been established in relation to authorization to possess dried marijuana, each with its own application requirements. In each case, the application is to be submitted by the patient, whose declaration must include information identifying the applicant and indicating that:

- The applicant is aware that no notice of compliance has been issued under the *Food and Drugs Act* concerning the safety and effectiveness of marijuana as a drug and that the applicant understands the significance of that fact; and
- The applicant has discussed the risks of using marijuana with a medical practitioner and consents to using it for the recommended medical purpose.

Category 1

- Eligibility: Applicants who suffer from a symptom associated with a medical condition for which the **prognosis is death within 12 months**.
- Conditions: A **medical practitioner** must provide a medical declaration indicating, among other things:
    - The applicant's medical condition and the symptom that is associated with that condition or its treatment;
    - The applicant suffers from a terminal illness;
    - All conventional treatments for the symptom have been tried or considered;
    - The recommended use of marijuana would mitigate the symptom;
    - The benefits from the applicant's recommended use of marijuana would outweigh any risks associated with that use;

[24] Health Canada, Information, *Medical Access to Marijuana – How the Regulations Work*, July 2001.
[25] Regulatory Impact Analysis Statement accompanying the *Marihuana Medical Access Regulations*, page 8.

- The medical practitioner is aware that no notice of compliance has been issued under the *Food and Drug Regulations* concerning the safety and effectiveness of marijuana as a drug;
- The applicant's recommended daily dosage and period of use.

Category 2

❖ Eligibility: Applicants who suffer from specific symptoms associated with some serious medical conditions, specially:
  - **Multiple sclerosis**: severe pain and/or persistent muscle spasms;
  - **Spinal cord injury**: severe pain and/or persistent muscle spasms;
  - **Spinal cord disease**: severe pain and/or persistent muscle spasms;
  - **Cancer**: severe pain, cachexia, anorexia, weight loss, and/or severe nausea;
  - **AIDS/HIV infection**: severe pain, cachexia, anorexia, weight loss, and/or severe nausea;
  - Severe forms of **arthritis**: severe pain; and
  - **Epilepsy**: seizures.[26]

	Severe Pain	Persistent Muscle Spasms	Cachexia	Anorexia	Weight Loss	Severe Nausea	Seizures
Multiple Sclerosis							
Spinal Cord Injury							
Spinal Cord Disease							
Cancer							
AIDS, HIV infection							
Severe form of Arthritis							
Epilepsy							

Source: Application for Authorization to Possess Dried Marihuana, Category 2 – Medical Specialist Form

❖ Conditions: Applicants must provide a declaration from a **medical specialist** to support their application, indicating, among other things:
  - The applicant's medical condition and the symptom that is associated with that condition or its treatment;
  - The specialist practises in an area of medicine that is relevant to the treatment of the applicant's medical condition;

[26] These symptoms are listed in a Schedule to the MMAR and were selected based on the outcome or conclusions of scientific and medical reports, although seizures associated with epilepsy were added in view of the findings in the *Parker* decision. This list is intended to be reviewed on a regular basis and is to be amended as new information becomes available.

- All conventional treatments for the symptoms have been tried or considered and were found to be medically inappropriate for reasons outlined in the Regulations;
- The recommended use of marijuana would mitigate the symptom;
- The benefits from the applicant's recommended use of marijuana would outweigh any risks associated with that use, including risks associated with long-term use of marijuana;
- The medical specialist is aware that no notice of compliance has been issued under the *Food and Drug Regulations* concerning the safety and effectiveness of marijuana as a drug; and
- The applicant's recommended daily dosage and period of use.

Category 3

- Eligibility: Applicants who have symptoms associated with a medical condition, **other than those described in Categories 1 and 2.**
- Conditions: Declarations from **two medical specialists** must accompany the application. The first declaration must indicate all information required under Category 2; all conventional treatments that have been tried or considered for the symptom; and the reasons, from those outlined in the Regulations, why the medical specialist considers that those treatments are medically inappropriate.

SYMPTOM(S)	**TREATMENTS**	**REASONS** – For each conventional treatment listed in the "Treatments" column, please provide the reasons why you consider that the treatment is medically inappropriate **(CHECK OFF THE APPROPRIATE BOX BELOW)**							
In the column below, please list the name of symptom(s) associated with the medical condition or its treatment and that is (are) the basis for the application	In the column below, for each symptom, please list the name of conventional treatments tried or considered	The treatment was ineffective	The applicant has experienced an allergic reaction to the drug used as a treatment	There is a risk that the applicant would experience cross-sensitivity to a drug of that class	The applicant has experienced an adverse drug reaction to the drug used as a treatment	There is a risk that the applicant would experience an adverse drug reaction based on a previous adverse drug reaction to a drug of the same class	The drug used as a treatment has resulted in an undesirable interaction with another medication being used by the applicant, or there is a risk that this would occur	The drug used as a treatment is contra-indicated	The drug under consideration as a treatment has a similar chemical structure and pharmacological activity to a drug that has been ineffective for the applicant

Source: Application for Authorization to Possess Dried Marihuana, Category 3 – First Medical Specialist Form

- The second declaration must indicate that, among other thingss: the specialist has reviewed the applicant's medical file and the reasons why the conventional

treatments are considered to be medically inappropriate; the specialist has discussed the applicant's case with the first specialist and agrees that the recommended use of marijuana would mitigate the symptom, and the benefits of the applicant's recommended use of marijuana would outweigh any risks associated with that use, including the risks associated with long-term use of marijuana; and the second specialist is aware that no notice of compliance has been issued under the *Food and Drug Regulations* concerning the safety and effectiveness of marijuana as a drug.

Dosage

The medical practitioner or specialist sets the daily dosage. If the recommended daily dosage is more than 5 grams per day, the medical practitioner or specialist must indicate that he or she has considered the risks associated with an elevated daily dosage of marijuana, including risks with respect to the effect on the applicant's cardio-vascular, pulmonary and immune systems and psychomotor performance, as well as the potential for drug dependency; and that in his or her medical opinion, the benefits of the applicant's use of marijuana according to the recommended daily dosage would outweigh the risks associated with that dosage, including risks associated with the long-term use of marijuana.

Maximum quantity possessed

The authorization to possess specifies the amount that may be possessed at any given time is a 30-day treatment supply. As explained above, the medical practitioner or specialist sets the daily dosage used to determine the 30-day treatment supply.

Duration

Generally, authorizations to possess are valid for one year and may be renewed.

Licence to produce

There are currently two possible legal sources for holders of an authorization to possess: they can grow their own supply or they can designate someone else to grow it for them. Health Canada has stated that, in the future, they should also be able to obtain it from a licensed supplier.

Only holders of an authorization to possess (personal-use production licence) or someone who has been designated as their representative (designated-person production licence) are eligible to hold a licence to produce. A designated person cannot be remunerated for their activities.

Conditions for obtaining a licence to produce include the following:

- A person cannot be the holder of more than one licence to produce;
- One site may be used for the production of marijuana under a maximum of three separate licences;
- The holder of a licence to produce must maintain measures necessary to ensure the security of the product;
- The production of marijuana outdoors is not permitted if the production site is adjacent to a school, public playground, day care facility or other public place frequented mainly by persons under 18 years of age;
- A person is ineligible for a designated-person production licence, who has been found guilty of a designated drug offence in the previous 10 years.

The licence specifies the maximum number of plants that may be cultivated. The licence also deals with the maximum quantity of dried marijuana that may be kept in storage and, in the case of a designated representative, the transportation of marijuana. The maximum amount of marijuana that may be cultivated and stored at any time depends on the daily dosage that has been set by the medical practitioner or specialist, and whether plants are grown indoors or outside. The regulations also deal with inspection powers and record-keeping requirements.

Other provisions

There are also provisions dealing with matters such as: measures to ensure the security of the marijuana in the possession of an authorized person; the revocation of licences; the showing of documents to police officers; the referral to police of complaints received by inspectors; and the disclosure of information about a medical practitioner to provincial licensing authorities of medicine. Of note is a transitional provision extending section 56 exemptions for an extra six months after the date of their expiry.

Health Canada has established an ongoing review process to monitor the effectiveness and application of the MMAR and provide advice on future measures related to the manufacture, distribution and sale of marijuana for medical purposes. This process involves a series of activities intended to collect information and seek input on various aspects of the MMAR. A 15-member committee representing a number of different stakeholder groups is currently being established, with a its first meeting planned in October 2002.

COMPASSIONATE ACCESS?

One of the objectives of the MMAR was to provide a compassionate framework for medical access to marijuana. In addition, one of the criteria used in choosing the current regulatory approach was that it *"must not unduly restrict the availability of marihuana to patients who may receive health benefits from its use."*[27]

While a process that authorizes the possession and production of marijuana has been established in Canada, this has not ensured that cannabis is suitably available to those in need. After careful review of the MMAR and thorough consideration of the evidence submitted to us, it is apparent that the MMAR have become a barrier to access. Rather than providing a compassionate framework, the regulations are unduly restricting the availability of cannabis to those who may receive health benefits from its use.

The following was stated in the Regulatory Impact Analysis Statement that accompanied the publication of the MMAR.

> *Due to anticipated increased visibility and efficiency of the new regulatory scheme and increased awareness of the potential uses or medical benefits of marihuana, it can reasonably be expected that the numbers of applicants will* **increase significantly**. *(emphasis added)*

As reported to us by Health Canada, as of 3 May 2002, 658 exemptions had been granted under the authority of section 56, and 501 were still active. In terms of the MMAR, 498 applications were received and 255 had been authorized as of the same date. In addition, 164 personal production licences and 11 designated personal licences have been issued. The rest of the files are open and are incomplete, awaiting more information or undergoing review.[28]

Thus, almost one year after the MMAR came into force, only 255 people have been authorized to possess marijuana for therapeutic purposes and only 498 applications have been received. These numbers are significantly lower than the number of exemptions that were granted under section 56 of the CDSA. Although 501 exemptions under section 56 are still active, it is clear that the number of applicants has not increased significantly as could "reasonably be expected" under the MMAR. In fact, the stated efficiency of the new regulatory scheme should be viewed with much scepticism. The low participation rate, in itself, should raise serious concerns among those sincerely aiming to provide compassionate access to cannabis for therapeutic purposes. In addition, the following sections will set out some of the specific problems

---

[27] Regulatory Impact Analysis Statement accompanying the *Marihuana Medical Access Regulations*, page 13.
[28] Gillian Lynch, Director General, Drug Strategy and Controlled Substances Programme, Health Canada, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-Seventh Parliament, 2001-2002, Issue No. 22, page 32.

that must be addressed if the regulatory scheme is to be truly efficient and compassionate.

Eligibility

The current framework requires an applicant to obtain a declaration from a medical practitioner (or one or two specialists) indicating that the recommended use of marijuana would mitigate the applicant's symptom and that the benefits from the applicant's recommended use of marijuana would outweigh any risks associated with that use. The medical practitioner must also determine the applicant's recommended daily dosage and period of use. A medical practitioner is defined as someone who is authorized under the laws of a province to practise medicine.

It is clear to everyone that requiring medical practitioners to act as "gatekeepers" in the use of marijuana for therapeutic purposes has created a major impediment to access, or, as Health Canada states, *"there is a conundrum"*. The Canadian Medical Association and many other professional medical organizations have refused to support the new federal application process because of issues of patient safety, dosages, and the legal liability of physicians prescribing cannabis.

This reluctance should not have come as a surprise to Health Canada. During the consultation process with regard to the proposed regulations, two medical associations and two provincial licensing authorities opposed the use of smoked marijuana for medical purposes. Their reasons included:

- The lack of scientific evidence supporting its use;
- The fact that marijuana is not an approved drug product;
- The view that the use of smoked marijuana is not an acceptable form of drug administration; and
- The view that the responsibility placed on doctors to support the use of marijuana for medical purposes may place them in conflict with professional conduct rules relating to the use of unapproved or "alternative" medicines.[29]

The position taken by the Canadian Medical Protective Association (CMPA) is fairly reflective of the positions taken by other individuals and organizations in the medical community. The CMPA is a medical mutual defence organization with 60,000 members–about 95 per cent of the physicians practising in Canada. It has warned its members that they could expose themselves to liability or professional misconduct complaints if they prescribe marijuana without "detailed knowledge" of the drug's risks and benefits and the appropriate dosage. The following was stated in an information sheet sent to members:

> *Section 69 of the regulations allows a medical licensing authority to request from the federal health minister information regarding a specific medical practitioner, which may be provided if the minister has*

[29] Regulatory Impact Analysis Statement accompanying the *Marihuana Medical Access Regulations*, p. 19.

> *reasonable grounds to believe the medical practitioner has made a false statement under the regulations. This is a significant concern, as physicians may unknowingly make a false statement because they are being asked to attest to matters that may go beyond the scope of their expertise. As a result, the risk that physicians could be reported to their College is increased.*
>
> *The fact that marijuana is not an approved drug product may lead some to conclude marijuana is an alternative medicine. This raises the important point as to whether the Colleges would consider physicians' involvement in the application for a licence to possess marijuana as requiring them to comply with the policy of that College concerning alternative or complementary medicines. The CMPA advises physicians to ascertain from their regulatory authority what their position is in this regard.*
>
> *Given the consequences that may befall physicians with respect to their licensing body, or potential medico-legal liability, physicians will want to be very careful when determining whether to assist a patient in making an application under these regulations.* [30]

The CMPA has also stated that the information about the effectiveness of medical marijuana in each patient's case, the relative risks and benefits of the drug and what dosage would be appropriate is "simply is not available," making it nearly impossible for the vast majority of doctors to comply with requirements of the MMAR. It views the MMAR as placing "an unacceptable burden on member physicians" and states that, since "many physicians would not have the necessary knowledge about the effectiveness, risks or benefits of marijuana, we believe it is unreasonable to make physicians gatekeepers in this process."[31] The CMPA advised its members as follows:

> *As you will see from the attached Information Sheet, now in the hands of our members, we have advised those physicians who are not or do not feel qualified to make those assessments to refrain from signing a declaration for a patient. We also advised our members to explain to their patients why they do not have the knowledge about marijuana, and to refer the patient to another physician, if known, with more experience in the medical use of marijuana.*
>
> *Finally, recognizing that some physicians, out of compassion for their patients, may believe in good faith that their medical condition would benefit from marijuana, we have advised them to complete only Parts 1 and 2 of the form and to* NOT *complete Parts 3, 4 and 5, leaving Health Canada to decide whether to process an incomplete application.* [32]

Clearly, under these circumstances, patients will have difficulty finding a medical practitioner willing to complete the required declaration forms, and even more difficulty accessing the appropriate specialists. This situation has created an unacceptable barrier to access and one must conclude that physicians should not be the

---

[30] Canadian Medical Protective Association, *What To Do When Your Patients Apply For A Licence To Possess Marijuana For Medical Purposes*, October 2001.

[31] Canadian Medical Protective Association, letter to the Honourable Allan Rock, Q.C., 8 November 2001.

[32] *Ibid.*

"gatekeepers" under the MMAR, a responsibility that they themselves do not desire. Even Health Canada recognizes that there is a problem.

> *Without that scientific evidence, the doctors are in a legitimate quandary. For other therapeutic products, doctors rely on information that Health Canada either develops or analyzes through the drug review process. That is the basis for doctors' understanding of the particular products. They do not have that analysis in this particular situation.*
>
> *Through the marijuana medical access regulations, we have eliminated the criminality of possessing and growing for your own purposes. That is the regulatory regime that is in place. We are working with Prairie Plant Systems, as Ms Lynch has said, to develop a research source for this product that will be made available through legitimate clinical trials for patients.*
>
> *Until such time as we can begin to get the results of the research and until the medical community can determine whether it will prescribe this in legitimate circumstances, there is a conundrum.*[35]

The involvement of physicians in the process is not questioned–what must be determined is their proper role with respect to use of cannabis for therapeutic purposes. Physicians are trained to provide a diagnosis of a person's medical conditions and symptoms and to determine how to treat these conditions and symptoms medically. Most do not have, however, adequate knowledge of the therapeutic benefits of cannabis and are reluctant to associate themselves with this product for a variety of reasons, including its illegality. In our view, and as we have explained in detail in Chapter 9, a distinction must be made between an approved medicine per se and a substance that has, at the very least, potential therapeutic applications–although these may not have been "scientifically" confirmed to date. Chapter 9 enumerates the conditions and symptoms for which cannabis has potential therapeutic applications. Let us be clear: we do not view cannabis as a "miracle" substance that will treat or cure numerous medical conditions or symptoms. It is a substance, however, that is known to provide effective relief of certain medical conditions and symptoms, thus improving the quality of life of many individuals.

In these circumstances, the proper role of the physician should be to make a diagnosis of the patient's medical conditions or symptoms. If the condition or symptom is one where cannabis has potential therapeutic applications, the patient would be authorized to use the therapeutic product of his or her choice, including cannabis. This would also mean eliminating the current requirement that all other "conventional treatments" have been tried or considered before the use of cannabis is authorized. There is no justification for making cannabis an option of "last resort."

---

[35] Dann Nichols, Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch, Health Canada, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-Seventh Parliament, 2001-2002, Issue No. 22, pages 37-38.

The requirement for specialist involvement in the current scheme clearly can lead to long delays. To make matters worse, the stated positions of medical organizations would make it very difficult to get two specialists to make the required declarations. This creates another unwarranted barrier.

> *The requirement to involve a medical specialist in the authorization of possession of medicinal cannabis is unjustified, unfounded, unrealistic and punitive. It negates timely access, and places an unjustified burden on both the patient and the Health Care system. Many patients already wait from nine months to a year to see a specialist. This means that those waiting for authorization to access medicinal cannabis may be on hold for upwards of a year. This is an inhumane wait to force upon those in dire medical need. In addition, it will unnecessarily exacerbate already extensive waiting lists for specialists, meaning those in genuine need of the specialists will unduly suffer.* [34]

The conditions and symptoms for which cannabis use would be authorized are set out in Chapter 9. New conditions or symptoms would be added based on ongoing research.

We are aware that the *1961 Single Convention on Narcotic Drugs* would seem to require medical prescriptions for the supply or dispensation of drugs to individuals.[35] We make two comments:

- International conventions are generally subject to a country's constitutional provisions. As previously discussed, courts in Canada have found that depriving an individual of the ability to choose marijuana as medication to alleviate the effects of a serious illness does violate the rights protected under the *Canadian Charter of Rights and Freedoms* unless there is a statutory exemption scheme authorizing such use. The courts have indicated that, where a statutory exemption scheme turns out to be "illusory," a constitutional exemption will be granted. The stated positions of Canadian medical organizations may make the current MMAR exemption scheme turn out to be "illusory."
- It is better to look to the spirit rather than the letter of the Convention. While cannabis may not be an approved medicine per se, there is no doubting its potential therapeutic applications. Thus, the Government of Canada should advise the international community that we will not strictly adhere to this requirement and that we will be requesting appropriate amendments to the international conventions.

---

[34] B.C. Compassion Club Society, *BCCCS Response to Health Canada's Proposed Medical Marijuana Access Regulations*, 4 May 2001, page 4.

[35] *Single Convention on Narcotic Drugs, 1961*, Article 30.2.b.i.

Access to cannabis

Concerns regarding patients' ability to grow marijuana on their own or to find a person willing and able to do it for them were often raised. This problem is compounded by the condition in the MMAR that a person cannot be the holder of more than one licence to produce. Problems associated with the present scheme include a lack of experience in cultivation; products of unknown potency and quality; security risks related to cultivation of marijuana; etc.

Undoubtedly, patients must have access to safe and high-quality cannabis products. The current option of self-cultivation should remain open for those who prefer this avenue. In such cases, the patient would register directly with Health Canada. In cases where self-cultivation is not appropriate or feasible, access should be permitted through properly regulated **Dedicated Cannabis Distribution Centres**. These centres would be staffed by personnel with knowledge of the therapeutic use of cannabis, who could advise patients on the dosage, strain and potency best suited for their particular conditions. The failure to obtain a domestic source of research-grade marijuana, as had been planned, provides further justification for allowing distribution centres to dispense high-quality cannabis to eligible patients. In addition, we are convinced that the government should not be the only distributor of cannabis intended for therapeutic purposes. Currently, Compassion Clubs play a very important role in distributing cannabis to those who need it for therapeutic purposes. For example, the B.C. Compassion Club Society is a registered non-profit society that has been distributing cannabis for medical use since 1997. It employs a staff of 28 and serves a membership of approximately 1,600 people. Before registering a member, the club requires a confirmation of diagnosis and a recommendation for cannabis from a physician, naturopathic doctor or a psychiatrist. If a doctor will not sign a recommendation solely because he or she is uncomfortable with the legal status of cannabis, or has concerns about professional retribution, the club may register the patient without a doctor's recommendation, depending on the severity of the diagnosis. Similar Compassion Clubs exist elsewhere in Canada.[36]

Access to a variety of strains of cannabis with varying levels of potency is crucial. For example, the B.C. Compassion Club Society currently stocks many varieties of cannabis products.

> *Our daily menu usually has seven to ten varieties of cannabis, one or two varieties of hashish, cannabis tincture and baked goods. It is important that medicinal users have access to a variety of strains, as the effect of cannabis varies depending on which strain is being used and the method of ingestion. Our members are made aware of the differences and can then select the best strain of cannabis to most effectively treat their symptoms.*[37]

---

[36] For example, the Vancouver Island Compassion Society currently has 235 members and the Club de compassion de Montréal has 130 members.

[37] Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 10, page 36

High-quality products would be ensured through proper testing. The importance of testing was raised as a key issue.

> *It is absolutely crucial in the developments on which we are working – and that we would like to continue – to have strict guidelines in terms of moulds and mildews, pesticides, fungicides, heavy metals and the kinds of things – which can be very dangerous – that you find in non-organic cannabis. Even in organic cannabis, some of those elements of microbiology can be very harmful to people, especially for people with depleted immune systems. We can only develop such standards when the medical marijuana community has access to laboratories. I think that there are all kinds of standards that can be developed in terms of safety and cleanliness in growing and distribution.* [38]

Despite what most would view as laudable motives–distributing cannabis to patients in order to alleviate their suffering–most of the existing clubs have faced or are facing difficulties with the justice system. Because they are operating in a grey area, those involved in these clubs are subject to prosecution and have in fact been prosecuted. For example, we heard from Philippe Lucas, director of the Vancouver Island Compassion Society (VICS), who indicated that he had been arrested and charged with possession for the purposes of trafficking because of his work with VICS. Mr. Lucas pleaded guilty to the charge but was recently granted an absolute discharge. Some of the comments made by the judge at sentencing are certainly relevant to this chapter. On the question of eligibility, the judge stated the following:

> *This case must be viewed in a broad context, in which to date, the combination of federal regulations and College of Physicians trepidation has made it extremely difficult for applicants to obtain approval to use marijuana.* [39]

He added the following with respect to access to marijuana:

> *Further, the federal government has so far been unable to ensure any legal supply of marijuana to those whom Health Canada thinks need it as a therapy. This is a particular hardship for those who cannot grow it.*
>
> *...the Crown cannot rely upon the argument that there is a lawful option for those in need of the drug when the evidence establishes that the drug is only theoretically available through legitimate sources.* [40]

---

[38] *Ibid.*, page 44.
[39] R. v. *Lucas*, Provincial Court of British Columbia, Victoria, File No: 113701C, para. 47 (Honourable Judge Higinbotham).
[40] *Ibid.*, para. 47-48.

In conclusion the judge stated the following.

> *I find that while there is no doubt that Mr. Lucas offended against the law by providing marijuana to others, his actions were intended to ameliorate the suffering of others. His conduct did ameliorate the suffering of others. By this Court's analysis, Mr. Lucas enhanced other peoples' lives at minimal or no risk to society, although he did it outside any legal framework. He provided that which the Government was unable to provide a safe and high quality supply of marijuana to those needing it for medicinal purposes. He did this openly, and with reasonable safeguards. The fact that he has stated he will continue this activity points to the sincerity of his principles, and points to our need as a society to get this thorny issue resolved quickly by either Parliament or the Supreme Court of Canada. If he re-offends, he will have to argue his case again, and may find a discharge difficult to obtain in the future. This court hopes that cooler heads will prevail pending the final resolution of issues regarding the medical and non-medical use of marijuana.* [41]

In Montreal, we heard how two volunteers of the *Club Compassion de Montréal* had been arrested only three months after they started operations. A decision is expected by the end of August 2002. Encouragingly, Hilary Black, founder and director of the B.C. Compassion Club Society, stated that the local police had generally been *"wonderfully supportive of their work."* However, her next statement reveals readily apparent contradictions.

> *Police who have come to the Compassion Club Society have told me what great work we are doing, and have, on one occasion, protected a safe full of cannabis on our behalf. However, I have had a police gun held to my head for being at a growing facility. While I met with the federal health minister, Alan Rock, to give recommendations and information Health Canada had requested from us, the RCMP raided a greenhouse that was growing low cost, organic cannabis for the Compassion Club Society. While I am here before you, sharing our information as experts in the distribution of medicinal cannabis, my colleagues risk arrest, imprisonment, their ability to travel, to be employed, and their freedom to distribute cannabis to those in need. Prohibition is not protecting Canadians from the evils of cannabis; prohibition is destroying Canadians' lives.* [42]

Because these organizations are presently operating in a grey area we would hope that those in charge of enforcement would use their discretion powers liberally and that cooler heads will prevail. Some of the statements made by Hilary Black led us to be optimistic in this area. Clearly, in other areas of the country, the political climate will have to change.

In order to create a transparent therapeutic distribution system, these centres should be licensed and properly regulated. The conditions of their operation should include a requirement that they be authorized only to distribute cannabis for therapeutic purposes to those who have been diagnosed as having an enumerated

---

[41] *Ibid.*, para. 49

[42] Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 10, page 41.

condition or symptom. In addition, the distribution centres would be required to keep suitable records and make periodic reports. The purpose of such information would be to keep Health Canada informed of the centres' members for registration purposes and also to provide valuable information for scientific research. Thus, the records would include information on a patient's medical condition and its evolution, the amounts consumed and the observed effects on the patient. The centres would also be required to ensure that security measures are in place and would be subject to inspections to ensure compliance with the regulations.

While added regulation will increase the costs of these distribution centres, this is essential to ensure proper controls over therapeutic use of medicinal cannabis. We insist that the costs of this regulatory scheme be kept to a minimum so as not to impede access to cannabis through inflated prices.

With respect to obtaining products, centres would agree to be supplied only by licensed producers. Such producers would be able to cultivate cannabis only for therapeutic purposes–since the separation of the therapeutic system from the recreational system is crucial. Licensed producers would be properly regulated–in particular, to ensure adequate safety measures are in place–and would be required to produce safe, high-quality products.

Products

Currently, the MMAR authorize possession of only dried marijuana, and not other cannabis products. We do not feel that this is justified and would recommend that the scheme be expanded to cover other cannabis derivatives .

Costs

We heard on several occasions that patients using cannabis for therapeutic purposes were often suffering from serious debilitating diseases, which negatively affected their financial situations. We recognize that drug coverage by insurance plans is generally a provincial responsibility. However, we believe that the purchase of marijuana for therapeutic purposes, and the purchase of equipment necessary for its cultivation, should be considered a medical expense for the purposes of the *Income Tax Act*.

Marihuana Medical Access Regulations	**Committee Proposals**
Eligibility	**Eligibility**
• The medical practitioner must not only confirm the applicant's medical condition and the symptom that is associated with that condition or its treatment, but also confirm that the recommended use of marijuana would mitigate the symptom and that the benefits from the applicant's recommended use of marijuana would outweigh any risks associated with that use	• The diagnosis of a medical doctor or other medical practitioner regulated by a provincial colleges of physicians and surgeons would suffice for the purpose of authorizing therapeutic use
• Requirement to consult one (category 2) or two (category 3) specialists for symptoms associated with medical conditions set out in category 2 and category 3	• Eliminate the requirement to consult one or two specialists
• Generally requires that all conventional treatments have been tried or considered	• Eliminate the requirement that all conventional treatments have been tried or at least considered before cannabis may be used
• Three categories of eligibility	• Eliminate the three categories and enumerate the medical conditions or symptoms for which cannabis use would be permitted – updating the list on a continual basis based on commissioned research
Access	**Access**
• Patients are limited to growing their own supply or designating someone to grow it for them	• Patients would be allowed to grow cannabis themselves or obtain it from dedicated distribution centres supplied by licensed producers
Products	**Products**
• Limited to cannabis (marijuana)	• Include all cannabis-derived related products
Dosage	**Dosage**
• Set by medical practitioner	• Would be determined by patient in association with the dedicated distribution centre

RESEARCH PLAN

Health Canada's Office of Cannabis Medical Access is responsible for the administration of the MMAR. It also co-ordinates other initiatives related to cannabis, including research on the safety and effectiveness of marijuana used for therapeutic purposes and the establishment of a reliable Canadian source of research-grade marijuana.

As stated previously, Health Canada released a report in June 1999 announcing a research plan for the therapeutic use of marijuana. The document[43] laid out a five-year research plan for evaluating the risks and benefits of the use of marijuana for medical purposes. The plan included the following elements:

- a research agenda composed of projects to address the issues of safety and efficacy of smoked marijuana and cannabinoids;
- mechanisms for medical access to marijuana outside the projects (for example section 56 exemptions discussed previously in this chapter); and
- the development of a Canadian source of research-grade marijuana.

Scientific research

As part of the government's strategy to address the issue of medical marijuana, Health Canada decided to sponsor research activities to evaluate the safety and efficacy of smoked marijuana and of cannabinoids. Health Canada was concerned that the evidence of the therapeutic value of smoked marijuana was heavily anecdotal and that the scientific studies supporting the safety and efficacy of marijuana for therapeutic claims were inconclusive. Health Canada was also concerned about the health risks associated with the use of marijuana, especially in smoked form.

The strategy has been developed with advice from the Therapeutic Products Programme's (TPP) Expert Advisory Committee on New Active Substances, an external body of scientific and medical experts who provided advice to the TPP.

Currently, there is a partnership program between Health Canada and the Canadian Institutes of Health Research (CIHR), a granting agency. This is to ensure scientific validity of the studies. The Health Canada/CIHR Medical Marijuana Research Program (MMRP) has been established as a five-year research plan with estimated funding of up to $7.5 million. The initial focus is on the smoked form of marijuana, although future initiatives are also to focus on non-smoked marijuana and cannabinoids.

We are aware of at least two studies that have been planned:

- In July 2001, Health Canada and the CIHR announced a contribution of $235,000 to fund a pilot study at McGill, with about 32 patients, aimed at evaluating the effects of smoked marijuana for chronic neuropathic pain.
- In June 2001, Health Canada announced funding of $840,000 to support a research project by the Community Research Initiative of Toronto (CRIT) on the efficacy of smoked marijuana in the treatment of wasting syndrome in those living with HIV/AIDS. At the time, it was entering the second phase of a three-part research project on smoked marijuana – The acute effects of smoked cannabis on appetite in persons living with HIV/AIDs (PHAs): A randomized, double-blind, placebo-controlled, crossover pilot study.

---

[43] Health Canada, Therapeutics Products Programme, *Research Plan for Marijuana for Medicinal Purposes : A Status Report*, 9 June 1999.

It should be noted, however, that neither of these projects is currently under way because they do not have access to marijuana.

In addition to pilot projects, Health Canada has announced that research-grade marijuana will be provided to eligible individuals who agree to provide health information for monitoring and research purposes. Health Canada will collect and analyse this information for research purposes. Once again, Health Canada has yet to provide marijuana to authorized users.

Health Canada has indicated that the knowledge gained from the overall research program will be used, in part, to amend the MMAR if necessary. For example, category 2 symptoms may need to be adjusted or the daily dosage may need to be more precisely determined. Health Canada also indicated that if no benefits were shown, the continued need of the MMAR would be in doubt.

Clearly, research on the therapeutic aspects of marijuana is essential. While Health Canada should be applauded for establishing a research plan, what is less commendable is the pace at which the research is progressing. As stated, the authorized pilot projects have yet to commence their research because Canada must rely on an American source for research-grade marijuana. This means that American institutions, in particular the National Institute on Drug Abuse, are entitled to review Canadian research protocols to determine whether or not they will deliver their marijuana products to Canadian researchers.

> *Our first source or our first attempt at sourcing the marijuana for research purposes was through NIDA, the National Institute on Drug Abuse in the States. They have seed and dried product. We are still negotiating with them to get some dry product.*
>
> *In order to use their product, we have to have the protocols that the product will be used for approved by both the health department there and NIDA themselves. Once they have approved the actual scientific protocol, then it has to go to the DEA to see if they will allow the export.* [44]

While further research is essential, it does not suggest that therapeutic use is not justified in specified circumstances. The ongoing research should focus on confirming its justification and on identifying new medical conditions or symptoms for which cannabis has therapeutic value. Research to determine the value of cannabis as a medicine per se should also be a priority, as should finding alternative delivery systems that are as effective as smoked cannabis.

Before leaving the issue of research, mention should be made of the considerable expertise and knowledge currently residing in the Compassion Clubs, which have become established outside of the legal system. This source of valuable

44 Gillian Lynch, Director General, Drug Strategy and Controlled Substances Programme, Health Canada, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-Seventh Parliament, 2001-2002, Issue No. 22, pp. 47-48.

information and expertise has not been acknowledged under Health Canada's current research plan. We feel strongly that the information they have must be gathered and analysed for research purposes. The validity of ongoing research using what some consider to be low-quality, low-potency cannabis imported from the National Institute on Drug Abuse or similar type of product that may be produced in Canada must also be called into question. Hilary Black, founder and co-director of the B.C. Compassion Club Society, stated the following.

> *We created a research proposal with a team of research scientists from Vancouver. However, we were turned down because we refuse to facilitate a study using a placebo or low-quality, low-potency cannabis imported from the US National Institute on Drug Abuse. Any study attempting to prove the efficacy of cannabis as a medicine using such a low-potency herb, or unknown strains such as those currently being grown in Canada by Plant Prairie Systems, is destined to fail. There is no need to import cannabis for research, considering the high quality and huge quantity of cannabis being produced in Canada. The information we could gather is being requested by doctors, patients, pharmaceutical companies, Plant Prairie Systems and Health Canada, yet we are not financially empowered to facilitate this research.* [45]

Research-grade marijuana

As was previously stated, another priority in Health Canada's research plan was the development of a Canadian source of research-grade marijuana. A request for proposal (RFP) was released on 5 May 2000 through Public Works and Government Services Canada. The purpose of the RFP was to establish a Canadian source of quality, standardized, affordable, research-grade marijuana for scientific research. Originally, the marijuana was to be made available only to qualified, approved scientists for research. A number of proposals were received by the closing date of 28 June 2000. The evaluation criteria included: financial status, qualifications of personnel, security requirements respecting personnel, etc. No experience in growing marijuana was required, although there was a requirement for experience in growing plant material for human consumption.

In December 2000, a contract was awarded to Prairie Plant Systems Inc. of Saskatoon (PPS) to provide Health Canada with a reliable source of affordable, quality, standardized marijuana for medical and research purposes. Health Canada also announced that until the domestic supply was established, it would submit requests to the U.S. National Institute of Drug Abuse to obtain research-grade marijuana for clinical trials being conducted in Canada on behalf of researchers.

PPS met the contract requirements for security and was given authorization to begin growing marijuana. The site chosen for the cultivation of research-grade marijuana in Canada was an abandoned mine in Flin Flon, Manitoba. While to some this appears comical, Health Canada justifies this decision because of the security this

45 Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 10, p. 10 :38-10 :39.

location provides and the opportunity to control the temperature, the humidity and the growing conditions.

The first product was expected to be delivered to Health Canada by early 2002. Under the terms of the five-year, $5.7 million contract that Prairie Plant Systems Inc. signed with Health Canada, the company would

- Set up and operate a marijuana growing, processing, fabrication and storage establishment;
- Conduct laboratory testing and quality control of marijuana throughout the product life cycle;
- Fabricate, package, label and store marijuana material;
- Distribute marijuana product to recipients authorized by Health Canada; and
- Conform to the requirements of the CDSA including stringent security and physical measures.

Health Canada also announced that this product would, in addition to use for research purposes, be made available to authorized Canadians using it for medical purposes who agree to provide information to Health Canada for monitoring and research purposes.

This spring, Health Canada revealed that the first crop could not be used for research purposes because of the varying quality. While they had hoped to obtain seeds from the National Institute on Drug Abuse, the seeds that were used were obtained from police seizures in Canada. This led to a collection of marijuana with different strains and characteristics. Health Canada states the importance of research-grade marijuana as follows:

> *Going back to the comments we made earlier on why Health Canada is involved in the study of medical marijuana, it is to determine whether to develop the scientific evidence that is required to determine whether there is a benefit. In order to develop that scientific evidence, one must have a base product that meets research standards. It was not a question of whether Prairie Plant Systems did in fact grow marijuana; it was a question of whether the product they developed was consistent, research-grade standard such that it could be used in legitimate scientific research.* [46]

While we are sympathetic to this argument, there would appear to be no justification for not supplying this product to those who have been authorized to do so under the CDSA, particularly since the safety of the product, in regard to pesticides, moulds, etc., should not be in question.

---

[46] Dann Nichols, Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch, Health Canada, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-Seventh Parliament, 2001-2002, Issue No. 22, page 46.

CONCLUSIONS

We would like to emphasize that the changes we propose to the MMAR still ensure that therapeutic use is limited to cases of legitimate medical need and that distribution and production is done under governmental licence.

Conclusions of Chapter 13

- **The MMAR are not providing a compassionate framework for access to marijuana for therapeutic purposes and are unduly restricting the availability of marijuana to patients who may receive health benefits from its use.**
- **The refusal of the medical community to act as gatekeepers and the lack of access to legal sources of cannabis appear to make the current regulatory scheme an "illusory" legislative exemption and raises serious Charter implications.**
- **In almost one year, only 255 people have been authorized to possess marijuana for therapeutic purposes under the MMAR and only 498 applications have been received – this low participation rate is of concern.**
- **Changes are urgently needed with regard to who is eligible to use cannabis for therapeutic purposes and how such people gain access to cannabis.**
- **Research on the safety and efficacy of cannabis has not commenced in Canada because researchers are unable to obtain the product needed to conduct their trials.**
- **No attempt has been made in Health Canada's current research plan to acknowledge the considerable expertise currently residing in the compassion clubs.**
- **The development of a Canadian source of research-grade marijuana has been a failure.**

CHAPTER 14

POLICE PRACTICES

Views on police priorities regarding enforcement of laws on illicit drugs are, at the very least, inconsistent, if not completely contradictory. Some believe that too much police time, effort and resources are spent in investigating illicit drug offences and, more specifically, possession offences – even more specifically, cannabis possession offences. Others–including the police themselves – claim that police priorities are already focused on traffickers and producers, and that possession charges are laid as a result of police presence to deal with other criminal activity. Thus, they maintain that the vast majority of cannabis possession charges are incidental to other police responsibilities.

This chapter will review the key organizations that are responsible for enforcing Canada's current illicit drugs legislation, the *Controlled Drugs and Substances Act* (CDSA). It will include a discussion of the powers they have been granted, and the investigative techniques used, in relation to illicit drug investigations. Finally, key police-related statistics will be explored. This information should help clarify some of the misconceptions related to enforcement of laws on illicit drugs.

ENFORCEMENT AGENCIES

Several organizations play a role in enforcing Canada's illicit drug legislation. This section will review three: the RCMP, the Canada Customs and Revenue Agency (CCRA), and provincial and municipal police forces. These key players co-operate with many other organizations when required, such as National Defence, Fisheries and Oceans, and the Canadian Coast Guard.

The RCMP

The RCMP's role and mandate is to enforce laws, prevent crime, and maintain peace, order and security. The RCMP is involved mainly in four components of Canada's Drug Strategy: enforcement and control; national co-ordination; international co-operation; and prevention programming.

At the national level, the RCMP's drug enforcement responsibilities are primarily carried out by two groups:

- The Drug Enforcement Branch: with approximately 900 employees, this branch is responsible for drug enforcement in Canada through its head office in Ottawa and its divisional drug enforcement units located throughout the country. The Branch also provides rapid communication to members of the international drug enforcement community.
- Integrated Proceeds of Crime Initiative: with about 415 employees, this group is responsible for investigating persons for proceeds of crime and seizing assets obtained through criminal activities. With an estimated 90 per cent of seizures related to drugs, it is primarily a drug-related initiative. The 13 units are staffed with a mix of: federal, provincial, and municipal police; Justice counsel; customs officers; tax investigators; asset managers; and forensic accountants. Cases tend to be complex and lengthy.

These two services also receive assistance from other RCMP sections such as intelligence and other specialized investigation services, including electronic and physical surveillance. Their current priorities lie in the investigation and arrest of upper echelon criminal organizations, involved in the drug trade, and in the seizing of proceeds of crime. The RCMP has adopted an intelligence-driven approach and conducts project-oriented investigations–for example, focusing on organized crime. It gathers information that is fed through its intelligence process to identify the main threats across the country. National priorities are based on these threat assessments so that resources will be focussed on the areas of greatest risk to Canadians. National priorities are reassessed, modified and retargeted based on gathered intelligence. Within those national priorities – for example, outlaw motorcycle gangs – particular groups will be specifically targeted. This approach has resulted in cases that are complex and lengthy and consume significant resources. Many of these investigations can take many years to come to fruition.

When it appeared before the Committee in October 2001, the RCMP set out the following national priorities:

> *Our current strategic national priorities are outlaw motorcycle gangs, Asian-based organized crime, Italian-based organized crime, and Eastern European-based organized crime. These are national targets; they are not drug targets. These are the RCMP national targets. These groups are involved in all commodity areas. However, you will notice that all four groups are involved in illicit drugs*[1]

The RCMP works closely with other national and international enforcement agencies in its efforts to reduce the supply of drugs in Canada. In this function, it will

[1] R..G. Lesser, Chief Superintendent, RCMP, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 8, page 11.

regularly participate in joint forces operations–which can be permanent working groups or temporary operations aimed at a specific target–to co-operatively investigate criminal activity and exchange intelligence. Liaison is maintained with provincial and municipal police departments, Interpol, the United Nations, the Organization of American States, National Defence, Fisheries and Oceans, Correctional Service of Canada, the Canadian Coast Guard, as well as Customs authorities and drug enforcement agencies worldwide, such as the Drug Enforcement Administration, FBI and U.S. Customs.

The RCMP is also involved in drug prevention and has established a Drug Awareness Service. With a budget of $4 million and 31 employees, this Service is responsible for going into the community to educate students, parents, athletes, coaches, employees, employers and community groups. The RCMP–including all personnel and not only the 31 full-time employees–makes over 10,000 presentations per year. Programs include Drug Abuse Resistance Education (DARE)[2], the Aboriginal Shields Program, the Two-way Street: Parents, Kids and Drugs, and the Drugs and Sport Program.

In addition to its federal responsibilities, the RCMP is involved in local enforcement as part of the provincial and municipal policing responsibilities it performs under contract. Sgt. MacEachern, Drug Enforcement Coordinator in New Brunswick, provided the following explanation:

> *The RCMP has a contractual obligation to the Province of New Brunswick and, as such, we provide policing services to all rural areas of the province, a large number of the smaller service districts and small municipalities, and as well a significant number of larger municipalities. In addition, we have federal law enforcement units throughout the province, and for drug enforcement we have offices and suboffices in Bathurst, Moncton, Saint-Leonard, Saint John and Fredericton.*
>
> *Simply put, our federal enforcement personnel dedicate themselves to larger scale investigations involving organized criminal groups at the provincial, interprovincial, national and international levels. Our provincial or contract detachments are tasked with targeting local or street level drug traffickers, but often, in the interests of addressing a significant local trafficking situation, our federal units combine resources with our detachments to pursue a specific goal.*[3]

While enforcement statistics are discussed in greater detail in following sections of this chapter, it is interesting to note that, according to the following chart from the Auditor General's 2001 Report,[4] the RCMP was responsible for approximately 24% of all charges under the *Controlled Drugs and Substances Act* in 1999, with only 4% of the charges relating to its federal policing services. In this chart, the number of persons

---

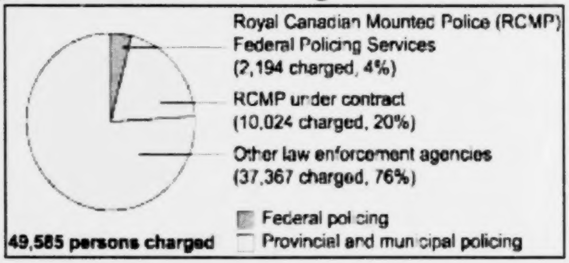
[2] DARE is discussed in greater detail in Chapter 17.

[3] Presentation submitted to the Committee on 5 June 2002.

[4] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role," p. 11.

charged is according to the most serious offence in a given incident and means persons charged by police or persons against whom the police recommended charges be laid.

Charges under the Controlled Drugs and Substances Act in 1999



The Canada Customs and Revenue Agency [5]

The CCRA–currently with over 8000 employees–has always played a key role in drug enforcement in Canada and is responsible for intercepting drugs at the point of entry. This is a significant task because many of the illicit drugs found in Canada are smuggled across our borders – although this statement may be less accurate with respect to cannabis, because of local production.

The *Customs Act* grants customs officers certain powers. Section 98 authorizes an officer to search a person arriving in Canada if the officer suspects on reasonable grounds that the person has secreted on or about his person: anything in respect of which the Act has been or might be contravened; anything that would afford evidence with respect to a contravention of this Act; or any goods the importation or exportation of which is prohibited, controlled or regulated under the Act or any other Act of Parliament. In addition, section 99 authorizes examination of goods that have been imported into Canada.

The CCRA deals with several types of contraband, including firearms, alcohol, tobacco and drugs. Like that of the RCMP, its work is intelligence-based, using information gathered through its own extensive intelligence network and through other enforcement agencies (both nationally and internationally). Thus, its contraband and intelligence program works with national and international enforcement agencies to develop information, indicators and trends to help identify suspicious shipments and/or persons before they arrive at the border.

The enforcement programs are based on strategic planning, risk management, information gathering and dissemination, partnerships, and effective training of

[5] This section relies to a great extent on the testimony of Mark Connolly, Director General, Contraband and Intelligence Services Directorate, Customs Branch, Canada Customs and Revenue Agency, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 8, pages 33-39.

personnel. The Contraband and Intelligence Services Directorate–with illegal drugs as its first priority–is responsible for the design, development, and implementation of strategies with regard to anti-smuggling and intelligence programs. Due to increasing volume, the CCRA implemented the Customs Action Plan–modernizing customs processes and introducing programs based on risk management.

The CCRA contraband and intelligence program is made up of intelligence officers, analysts, and databases to support front-line customs inspectors in identifying high-risk persons and goods at our borders. These units are responsible for collecting and developing intelligence and disseminating it to the line officers across the country.

The CCRA maintains alliances with other customs administrations, national and international law enforcement agencies, and external stakeholders in connection with contraband, intelligence, strategic export and counter-terrorism programs. It has also built important partnerships with other law enforcement agencies in Canada, such as the RCMP and provincial and municipal police, and around the world with other customs administrations and law enforcement agencies such as the United States Customs Service, the Drug Enforcement Agency, the World Customs Organization, the Caribbean Customs Law Enforcement Council, and Interpol. The CCRA regularly participates in joint-force operations of both short- and long-term duration. For example, the Integrated Border Enforcement Teams (IBETS) is a multi-agency law enforcement initiative between Canada and the United States to address cross-border crimes. In addition, the CCRA and police pool resources on a daily basis with local, state and provincial enforcement agencies to combine expertise and intelligence. The CCRA is also part the Integrated Proceeds of Crime initiative discussed above.

Specific activities in relation to drug enforcement include:

- Use of highly sophisticated contraband detection equipment to conduct non-intrusive examinations to assist in the identification of narcotics – X-ray systems, including baggage, mobile truck and rolling cargo systems; ion scans used to detect trace amounts of narcotics on almost any surface; detector dog teams deployed across the country; contraband detection kits that include a number of useful tools such as probes and fibrescopes; and one submersible remote-operated vehicle used to detect narcotics and other contraband attached to the hull of ships, below the water level.
- Emphasis on training its customs inspectors in the area of contraband enforcement.
- Use of several enforcement systems and databases, both internal and external, which allow customs officers and inspectors to identify the level of risk of travellers, carriers and/or drivers.
- Deployment of dedicated enforcement personnel to enhance intelligence and interdiction in the regions. Regional Intelligence Officers work with local police authorities, targeters, investigators and customs officers to identify high-risk movement across the border. Flexible Response Teams consist of highly trained customs officers who have been placed across Canada to perform monitoring and

compliance verification activities, as well as sampling stints on travellers chosen on a random basis. Regional Intelligence Analysts analyze large seizures to identify links to organized crime; they also conduct threat assessments based on trends, and help identify future risk.

The CCRA estimates that it is responsible for approximately 50% of all drug seizures in Canada.

Provincial and municipal police

Provincial and municipal police forces handle the majority of drug cases in Canada. They are involved primarily in enforcing illicit drug legislation at the street level. In addition, members of these forces are often involved in joint operations with the RCMP and/or the CCRA and other enforcement agencies. For example, the Committee was informed of joint operations currently being run with the RCMP–and in certain cases other enforcement agencies–and the Toronto Police Service, the Vancouver Police Department and the Regina Police Service.

COSTS [6]

The Committee had requested certain details from police forces such as the proportion of time officers spend on drug-related cases, the number of officers assigned to drug enforcement, etc. In most cases, we either received no response to these questions or very general broad statements. Either the police forces were not willing to share this information or police work does not lend itself to these types of calculations and no one knows how much is spent on drug enforcement. In either case, the lack of data makes it extremely difficult to estimate how much of police budgets is allocated to drug-related matters and to analyze whether or not public funds are efficiently allocated.

Estimating the cost of drug enforcement is a fairly complex exercise. Questions raised include: Which items should be included? Which items should be left out because of a lack of data? How should each cost element be measured? Are such costs truly avoidable? How are items to be costed? Finally, what is the effect of these factors on the quality of the results?

---

[6] This section relies to some extent on *The Costs of Drug Abuse and Drug Policy*, a paper prepared for the Special Senate Committee on Illegal Drugs by Antony G. Jackson, Economics Division, Parliamentary Research Branch, Library of Parliament, 22 April 2002.

The Canadian Centre on Substance Abuse (CCSA) undertook the latest major study of the costs of drug abuse in Canada.[7] This study was published in 1996 and relates to 1992 data. Law enforcement costs were estimated as:

Police	**$208.3M**
Courts	$59.2M
Corrections (including probation)	$123.8M
Customs and Excise	**$9.0M**
Total law enforcement costs	$400.3M

Police costs consisted of the costs for specialized law agencies such as the (then) RCMP Narcotics Division, plus that fraction of the general costs of operations that could be attributed to dealing with illicit drug crimes. Such crimes included both direct violations of the drug laws and also that proportion of general crimes that could reasonably be attributed to illicit drugs.

Data existed on the proportion of homicide and assault cases in which the perpetrator was under the influence of illicit drugs. The CCSA study estimated the proportion of those cases where the assault or homicide could be causally attributed to the drug intoxication of the perpetrator. Putting these two together, it estimated that 8% of violent crimes were attributable to illicit drugs in Canada. No such figure was estimated for property crimes.

The measure of police output was the offence. To estimate policing costs, total policing expenditures as reported by Statistics Canada were multiplied by the percentage of offences that were estimated to be drug-related. The CCSA study concluded that in 1992, 2.4% of all offences were attributable to illicit drug use.

Policing costs of enforcing federal drug laws	$168.4M
Policing costs of 8% of violent crimes	$39.9M
Total policing costs	$208.3M

The Customs and Excise figure excluded programs financed under the Drug Strategy.

While we are unable to conduct an in-depth study of enforcement of laws on illicit drugs costs in relation to the RCMP, the CCRA and provincial and municipal police, we can assert with certainty that the current costs of enforcement of laws on illicit drugs are significantly higher than the approximately $210 million estimated in 1992.

The Auditor General's 2001 report estimated that the RCMP alone spent approximately $164 million in 1999 on enforcement of laws on illicit drugs.[8] This

[7] Single, E., et al., (1996) *The Costs of Substance Abuse in Canada: A Cost Estimation Study*, Ottawa: Canadian Centre on Substance Abuse.

estimate was based on detailed expenditure data gathered by the federal drug enforcement program. The amount included costs directly related to drug enforcement as well as costs in related areas such as proceeds of crime and customs and excise initiatives.

The $164 million applies **only** to RCMP federal policing services, however, and not to the policing services rendered by the RCMP under contract to a province or municipality, which account for the largest share of the force's budget. We were told that, at present, it was not possible to ascertain the costs related to the enforcement of laws on illicit drugs for the latter functions.

> *In the case of contract policing, enforcement of drug laws is rendered in conjunction with a number of other services as, typically, the officers under contract are performing uniform duty, that is, general policing duties in communities. It is therefore difficult to determine what portion of their time is spent doing which activity. This difficulty is enhanced when the drug offence is incidental to another crime, which is often the case.*
>
> *One must consider that a large portion of the cost of any police service is the pay and benefits extended to its members. In order to accurately determine the cost of drug enforcement in contract policing, the amount of time devoted to the effort must be measured.*
>
> *While this is done for members of the RCMP employed in the federal services, the present system applied to contract policing is incapable of collecting this information. An effort is being made to develop a new system that could possibly capture this information. However, given the breadth of day-to-day contract policing duties, it is a clear challenge to separate out, in a meaningful way, drug-related activity.*
>
> *...I should like to speak now to the cost borne by provincial and municipal police forces. We have recently begun a process to determine what information exists on enforcement costs and where the gaps lie. Last month, at the most recent meeting of the National Coordinating Committee on Organized Crime, which I chair, our department distributed a questionnaire to collect existing information on the cost of enforcement in the provinces and territories. The questionnaire has since been distributed to police forces across the country through the Canadian Association of Police Boards. We are very interested in analyzing the results once we have received them.*[9]

This Committee is obviously also very interested in these results, since they would provide the most accurate information available to date. As previously explained, we found it extremely difficult, if not impossible, to obtain any specific details on cost breakdowns for drug-related activities for provincial and municipal police forces. While Chief Fantino of the Toronto Police Service indicated that "probably one-third of our

[8] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role," page 17.

[9] Paul E. Kennedy, Senior Assistant Deputy Solicitor General, Policing and Security Branch, Department of the Solicitor General, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 22, pages 9-10.

resources are sucked right up in some form or another relating to drug work,"[10] this type of statement is insufficient to permit concrete conclusions with respect to policing costs. What we did hear was that drug investigations–in particular those targeting trafficking networks–can be very resource-intensive for police forces.

> *It is a large pull on resources, due to the nature of the work. The work is complex and, as you point out, it involves surveillance. It will sometimes involve wiretap surveillance as well. It requires a network of people who work in a clandestine fashion. It takes the police a long time to assemble credible evidence to reveal the network, make the connections, and then to correlate all of that for the court. It is a very resource-intensive aspect of policing, therefore, it is very expensive to the police department.* [11]

It is not clear, however, whether the same rationale with respect to costs applies in the case of cannabis possession.

> *Cannabis use is, except as it is incidental to an encounter with a police officer, not a target of police investigation at this time, at least not in this community. We do not go out and seek people who are simply using cannabis. We do encounter them, however, as we go about our business in many other circumstances. We encounter them as one part of the drug investigation into trafficking, so we see the users there and some charges arise. We see them in domestic disputes. We see users in drinking establishment investigations and sometimes in traffic-infraction situations. Their presence is incidental to the investigation.*
>
> *As far as targeting cannabis trafficking and cannabis cultivation, that is a mainstream of the drug investigations. The money from cannabis cultivation and cannabis trafficking does flow into other aspects of crime. In some communities it is most definitely formal, organized crime; in other communities it is groups of affiliated criminals who are involved for profit only. We direct our activity to those areas.* [12]

With respect to customs-related costs, the CCRA indicated that of its $410 million budget for 2001-2002, it can be estimated that $75 million is dedicated to the interdiction of illegal drugs, in areas such as: Flexible Response Teams; district-targeting units; the container examination program; the marine centre of expertise; regional intelligence analysts; and regional intelligence officers. In addition, costs were associated with contraband detection technology that includes: X-rays; ion-mobility spectrometers; and the Detector Dog service. The CCRA did indicate that the officers involved in contraband detection are not dedicated solely to drug enforcement but to contraband enforcement in general–although illicit drug interdiction was their first priority. The

[10] Chief Julian Fantino, Toronto Police Service, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 5, page 11.
[11] Chief Cal Johnston, Regina Police Service, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 16, page 31.
[12] *Ibid.*, page 33.

Auditor General's 2001 report had estimated the CCRA's enforcement expenditures at between $14 and $36 million for illicit drug interdiction. [13]

The numbers indicated below have been selected from the following sources:

- RCMP (federal policing services) – Auditor General's 2001 report and testimony before the Committee;
- Provincial and municipal forces and RCMP (under contract) – by multiplying the estimated total policing expenditures for municipal and provincial policing of $5.0 billion (in 1997-1998, expenditures totalled $4.8 billion – excluding RCMP federal policing services expenditures)[14] by 3.5% (the percentage that illicit drug offences represented of all CDSA and *Criminal Code* offences in 2001: 91,920 CDSA offences and 2,534,319 *Criminal Code* offences = 2,626,239 total CDSA and *Criminal Code* offences)[15]; and
- CCRA – based on an estimate between figures provided in the Auditor General's 2001 report ($14 to $36 million) and the CCRA's testimony before the committee ($75 million).

While this is a crude and unscientific method of calculation and does not take into account a series of factors that would certainly lead to adjustments, it does provide some basis for comparison.

RCMP (Federal Services)	$164 million
Provincial and municipal policing	$175 million
CCRA	$50 million
Total	**$389 million**

As indicated above, given the fact that drug investigations are extremely resource-intensive, drug enforcement may be assumed to represent much more than 3.5% of policing budgets. Chief Fantino of the Toronto Police Service indicated that it was probably closer to 33% of his budget. Even if a conservative number such as 15% were used, the figure for provincial and municipal policing costs would increase to $750 million. **This would mean that almost $1 billion is being spent on drug enforcement in Canada every year.** Clearly, not all costs would be recoverable, even under a legalized system. For example, already overburdened police forces would surely

[13] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role," page 16.

[14] Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Justice Spending in Canada, Catalogue no. 85-002-XIE, Vol. 19, No. 12, pages 4-6.

[15] Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Crime Statistics in Canada - 2001, page 14.

redirect resources to other priorities. However, significant savings could reasonably be expected, if the cannabis laws were relaxed.

> *...the actual savings in law enforcement costs attributable to changing prohibition of possession are hard to estimate. The difficulty occurs in part because cannabis arrests have decreased in recent years in Vancouver reflecting the overall tendency to relax enforcement for simple possession. Nevertheless,* **reduced law enforcement activities would have substantial savings if the law was repealed or changed.**[16] *(emphasis added)*

POLICE POWERS [17]

There are those who argue that police have been granted powers that are far too extensive in relation to drug enforcement and that in this fight against drugs, society has come to tolerate a battery of investigative techniques–wiretapping, strip-searches, the use of paid informants, entrapment, etc–which are offensive to our basic notions of civil liberty. As will be discussed in more detail, the nature of drug offences renders them difficult to enforce. This results in police agencies requesting and using a variety of unusual methods of enforcement. While there is a long history of special police powers in relation to drug enforcement, this chapter will focus primarily on modern police powers.

No one questions the fact that police require powers for the maintenance of law and order in our society. In investigating criminal offences, the police may use less intrusive investigative techniques such as observation and interrogation. In other cases, they may be required to use more intrusive methods such as electronic surveillance and reverse sting operations. While such methods are not limited to drug enforcement and may be used in other criminal matters, they are certainly used much more extensively in drug investigations.

These powers must be constrained, however, so as to protect individuals from excessive police activity. As stated by La Forest J.: "*The restraints imposed on government to pry into the lives of the citizen go to the essence of a democratic state.*"[18] In determining whether police conduct is acceptable, conflicting interests generally have to be weighed. First, there are the individual's interests, including the interest of being free from state intrusion. Second, there are the state's interests, including that of protecting society

[16] Kash Heed, Vice Drugs Section, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 10, page 62.

[17] This section is in essence a summary of *Police Powers and Drug-Related Offences*, a paper prepared for the Special Senate Committee on Illegal Drugs by Gérald Lafrenière, Law and Government Division, Parliamentary Research Branch, Library of Parliament, 6 March 2001.

[18] *R. v. Dyment*, (1988) 45 C.C.C. (3d) 244 at p. 254 (S.C.C.).

from crime. Because these interests generally conflict, it can sometimes be difficult to agree on where the line should be drawn in relation to police conduct.

The courts have recognized that, as crimes become more sophisticated, police must be able to use more sophisticated investigative techniques to detect their commission. In addition, with respect to drug-related offences and other consensual types of offences,[19] it is acknowledged that routine investigative techniques are often insufficient because of the difficulty in detecting these activities. Generally, because there is no "victim," no one is there to complain or report the offence to police. Both Parliament and the courts appear to agree that additional police powers may be warranted in these circumstances. It is believed that police need to be proactive, rather than reactive, as is generally the case for other non-consensual offences. An example of this viewpoint is expressed in the following statement by former Chief Justice Laskin of the Supreme Court of Canada:

> *Methods of detection of offences and of suspected offences and offenders necessarily differ according to the class of crime. Where, for example, violence or breaking, entering and theft are concerned, there will generally be external evidence of an offence upon which the police can act in tracking down the offenders; the victim or his family or the property owner, as the case may be, may be expected to call in the police and provide some clues for the police to pursue. When "consensual" crimes are committed, involving willing persons, as is the case in prostitution, illegal gambling and drug offences, ordinary methods of detection will not generally do. The participants, be they deemed victims or not, do not usually complain or seek police aid; this is what they wish to avoid. The police, if they are to respond to the public disapprobation of such offences as reflected in existing law, must take some initiatives.*[20]

The Le Dain Commission had also recognized the special nature of drug offences.

> *The peculiar nature of drug crimes–the fact that the people involved in them are consenting and co-operative parties, and there is rarely, if ever, a victim who has reason to complain, as in crimes against persons and property – makes enforcement of the drug laws very difficult. The police are rarely assisted by complainants. For the most part they have to make their own cases. Moreover, the activity involved in non-medical drug use is relatively easy to conceal. It can be carried on, by agreement of the parties involved, in places which are not easily observed by the police. Further, the substances and equipment involved are relatively easy to conceal or dispose of.*
>
> *All of these difficulties have given rise to the development of unusual methods of enforcement.*[21]

---

[19] Other consensual offences include gambling and prostitution.

[20] R. v. *Kirzner* (1977) 38 C.C.C. (2d) 131 (S.C.C.) at page 135.

[21] Commission of Inquiry into the Non-medical Use of Drugs (1972) *Cannabis*, A Report, Ottawa, page 239.

Searches and seizures

Special powers of search and seizure have long been part of drug law enforcement practices. For example, before they were eliminated in 1985, writs of assistance generally gave peace officers the power to search without first having to obtain a warrant. Such powers were found in previous versions of the *Customs Act*, the *Excise Act*, the *Food and Drugs Act* and the *Narcotic Control Act*. Before its repeal in 1985, section 10(1) of the *Narcotic Control Act* allowed peace officers acting under *"the authority of a writ of assistance or a warrant"* to enter and search a dwelling-house "at any time," so long as the peace officer had a reasonable belief that there was a narcotic in the house *"by means of or in respect of which"* an offence under the Act had been committed. Section 8 of the Charter eventually put an end to writs of assistance.

Today, the CDSA establishes a comprehensive search and seizure scheme for drug-related offences. Although these provisions are similar to the search and seizure provisions of the *Criminal Code*, police have some additional powers under the illicit drug legislation. Section 11(1) allows a justice to issue a search warrant if he or she is satisfied by information on oath that there are reasonable grounds to believe that specific items are in a place. These items are:

- A controlled substance or precursor in respect of which the CDSA has been contravened;
- Anything in which a controlled substance or precursor referred to in the previous paragraph is contained or concealed;
- Offence-related property; or
- Anything that will afford evidence in respect of an offence under the CDSA.

A warrant may be obtained even though there is no reason to believe that there are illicit drugs in the place being searched, so long as there are grounds respecting the presence of one of the other three types of items.

The CDSA authorizes a search **"at any time."** Thus, there is no requirement to obtain authorization to search at night, as in the case of a search under the *Criminal Code*.

Another special power is found in subsection 11(5), which allows the police to **conduct searches of the person** in certain circumstances. This power is not found in the *Criminal Code*, although the police do have power of search incidental to arrest under common law. The CDSA gives the police, in the process of executing a search warrant, the power to search a person for a controlled substance or other specified items. This can be done only if the officer has reasonable grounds to believe that the person found in the place set out in the warrant has in his or her possession a controlled substance or other specified items set out in the warrant. Thus, this provision authorizes the police to conduct a search of the person even if no arrest is made, but only for specified items and only if the police have reasonable belief of certain facts.

Subsection (7) allows the police to conduct a search described in subsections (1), (5) or (6) without a warrant *"if the conditions for obtaining a warrant exist but by reason of exigent circumstances it would be impractical to obtain a warrant."* As will be discussed later, warrantless searches are presumed to be unreasonable, but the courts have allowed for exceptions. The rules have been summarized as follows:

> *A warrantless search has been justified where, based on the circumstances of the search, it was not feasible to obtain the warrant; for example, where a vehicle, airplane or other conveyance having the ability to change location is the subject of the search. The onus in such cases is on the Crown to establish that the obtaining of a warrant in the circumstances of the specific case would impede the effectiveness of the enforcement of the law.*
>
> *Where there is no common law search power regarding searches in "exigent circumstances", the courts have held that it is necessary for the enabling legislation to specifically refer to a warrantless search power in certain circumstances, for example, exigent circumstances. Such legislative provisions should narrowly define the type of investigation which would permit the use of a warrantless search.* [22]

Although exigent circumstances may be created by the presence of drugs in a vehicle, whether a warrantless search of a person's home in exigent circumstances will be found to be constitutional is still in doubt.[23] The courts will require some public interest sufficiently compelling to override the privacy interests attaching to the home. One example of such a compelling interest is the preservation of human life or safety.[24]

The legislation also allows: a police officer to seize things not specified in the warrant if the officer believes on reasonable grounds that they are items mentioned in subsection (1);[25] and the power to seize anything that the officer believes on reasonable grounds has been obtained by or used in the commission of an offence (not limited to drug offences) or will afford evidence in respect of an offence.[26]

The CDSA also deals with the use of force. Section 12 allows a police officer who is executing a warrant to "enlist such assistance as the officer deems necessary" and *"use as much force as is necessary in the circumstances."* It should be noted that the search provisions in the *Criminal Code* do not specify that force may be used, although this is set out in other sections of the *Criminal Code*.

Things seized under the CDSA can be classified as either offence-related property (for example, money and automobiles) or controlled substances ("drugs"), with specific rules regarding detention and forfeiture for each category. The legislation also provides for the search, seizure, detention and forfeiture of proceeds of crime in relation to

---

[22] Brucker, T. (2002) *The Practical Guide to the Controlled Drugs and Substances Act*, Third Edition, Carswell, page 101.

[23] In R. v. *Feeney*, the Supreme Court of Canada refused to deal with the issue because, according to the Court, exigent circumstances did not exist when the arrest was made.

[24] R. v. *Godoy*, (1999) 131 C.C.C. (3d) 129 (S.C.C.).

[25] See *Controlled Drugs and Substances Act*, section 11(6).

[26] See *Controlled Drugs and Substances Act*, section 11(8).

drug-related offences by incorporating the proceeds of crime provisions of the *Criminal Code*.

Section 8 of the Charter–warrantless searches

Section 8 of the Charter provides that everyone has the right to be secure against unreasonable search and seizure. Court decisions have dealt with the question of whether searches are reasonable in various situations and with the ancillary question of whether evidence obtained during the searches can be adduced at trial. A search will generally be reasonable if it is authorized by law, the law itself is reasonable, and the search is carried out in a reasonable manner.

Section 8 protects the public's reasonable expectation of privacy from state intrusions. Thus, where there is no reasonable expectation of privacy, section 8 does not apply. In addition, a diminished expectation of privacy (for example, in prisons or at border crossings) will lower the standard of reasonableness (for example, excusing the absence of a warrant or reducing the standard required for justifying the search). A person's home is where there would be the greatest expectation of privacy and thus a greater degree of constitutional protection.

Although the Charter does not specifically require that police obtain a search warrant to conduct a search, the Supreme Court of Canada in *Hunter* v. *Southam Inc.* has established a presumption that a warrantless search is unreasonable.[27] The general rule for a valid search is that the police will require prior authorization to conduct the search (for example, by obtaining a search warrant) and reasonable and probable grounds to justify it. This is to provide a safeguard against unjustified state intrusion.

This is the general rule; however, there are exceptions. It is recognized that a prior authorization is not always feasible. With respect to these exceptions, the courts require some authority, in statute or at common law, to conduct warrantless searches. The existence of such authority is not enough, however, because the courts will also review this authority to ensure that it is reasonable. In defining what is reasonable, the courts have established that warrantless searches should generally be limited *"to situations in which exigent circumstances render obtaining a warrant impracticable."*[28] In R. *v. Grant*, the Court stated:

> *To sum up on this point, s. 10 may validly authorize a search or seizure without warrant in exigent circumstances which render it impracticable to obtain a warrant. Exigent circumstances will generally be held to exist if there is an imminent danger of the loss, removal, destruction or disappearance of the evidence if the search or seizure is delayed. While the fact that the evidence sought is believed to be present on a motor vehicle, water vessel, aircraft or other fast moving vehicle will often create exigent circumstances, no blanket exception exists for such conveyances.*[29]

[27] *Hunter (Director of Investigation & Research)* v. *Southam Inc.* (1984) 14 C.C.C. (3d) 97 (S.C.C.).
[28] R. v. *Grant* (1993) 84 C.C.C. (3d) 173 (S.C.C.) at p. 188.
[29] *Ibid.*, page 189.

While every case will be reviewed on its merits, the greater the degree of urgency the police can demonstrate in the circumstances, the more inclined a court will be to find the warrantless search reasonable.

Searches of the person

Apart from a few specific provisions, such as the one found in the CDSA, federal criminal law does not provide authorization for a search of the person. The common law does, however, allow a search of the person incidental to a lawful arrest. This common law power is an exception to the general rule that a search requires prior authorization to be reasonable. This is a very important exception, because most searches of the person are done pursuant to this power. As explained earlier, the CDSA does allow a police officer who is executing a search warrant under that Act to search people who are present, under certain conditions.

A person may be searched under the common law power only for the purpose of locating further evidence relating to the charge upon which he or she has been arrested or to locate a weapon or some article that may assist him or her to escape or commit violence. Although the power to search incidental to an arrest is fairly broad, there is no automatic unrestricted right to search incidental to an arrest.

Manner in which search conducted

Courts have shown a willingness to scrutinize the manner in which a search of the person is conducted. For example, in *Collins*, a British Columbia case, the accused was sitting in a bar that was said to be frequented by heroin users and traffickers. The accused was seized by two police officers; while one of them used a choke-hold that rendered her semi-conscious, the other forced open her mouth. While this was happening, three caps of heroin dropped out of the accused's right hand. The Court held that the officers in this case had not had reasonable and probable grounds to believe that narcotics were in the accused's mouth and that therefore the search was unlawful. The Court went further and determined that to admit the evidence would bring the administration of justice into disrepute, for it would condone and allow the continuation of unacceptable conduct by the police. This decision was affirmed on appeal by the Supreme Court of Canada. This does not mean that a choke-hold will always be considered unreasonable. The following was stated in R. *v. Garcia-Guiterrez*.[30] *"a choke-hold was used to prevent the evidence from being swallowed and a punch to the solar plexus to force the suspect to cough it up. Subject to a strongly worded dissenting opinion, the majority of the B.C. Court of Appeal held that the choke-hold to preserve evidence was acceptable in the circumstances."*[31]

Searches of the person authorized by statute and the common law generally provide no indication as to the scope of the search that can be carried out. As discussed above, one of the requirements of a reasonable search is that it be executed in a

[30] (1991) 65 C.C.C. (3d) 15 (B.C.C.A).

[31] Fontana, J.A. (1997) *The Law of Search and Seizure in Canada*, Fourth Edition, Butterworths, page 396.

reasonable manner. With respect to searches of the person, the level of intrusion may render the search unreasonable.

When discussing body searches in border areas, the Supreme Court of Canada distinguished between three categories of searches:

> *It is, I think, of importance that the cases and the literature seem to recognize three distinct types of border search. First is the routine of questioning which every traveller undergoes at a port of entry, accompanied in some cases by a search of baggage and perhaps a pat or frisk of outer clothing. No stigma is attached to being one of the thousands of travellers who are daily routinely checked in that manner upon entry to Canada and no constitutional issues are raised. It would be absurd to suggest that a person in such circumstances is detained in a constitutional sense and therefore entitled to be advised of his or her right to counsel. The second type of border search is the strip or skin search of the nature of that to which the present appellant was subjected, conducted in a private room, after a secondary examination and with the permission of a customs officer in authority. The third and most highly intrusive type of search is that sometimes referred to as the body cavity search, in which customs officers have recourse to medical doctors, to X-rays, to emetics, and to other highly invasive means.* [32]

In the *Simmons* case, Dickson C.J.C. went on to add that the different types of searches raise different issues and entirely different constitutional issues *"for it is obvious that the greater the intrusion, the greater must be the justification and the greater the degree of constitutional protection."*[33] This approach was confirmed in the 1999 Supreme Court of Canada decision in *Monney* (discussed below). In both cases, the constitutionality of the third category of searches was left open, while the first two categories were held to be reasonable under section 8 even if based only on suspicion. It should be noted that these cases were decided in the context of border searches.

The Supreme Court of Canada indicated the following with respect to frisk searches in the context of a search incidental to arrest:

> *A "frisk" search incidental to a lawful arrest reconciles the public's interest in the effective and safe enforcement of the law on the one hand, and on the other its interest in ensuring the freedom and dignity of individuals. The minimal intrusion involved in the search is necessary to ensure that criminal justice is properly administered.* [34]

Thus, when a search of the person is justified, a frisk search will generally be held to be reasonable because it is the least intrusive means available to conduct one.

Strip searches were considered in R. v. *Flintoff*.[35] A police officer arrested the accused at the scene of an accident for impaired driving. The accused was strip-searched before the breath tests, pursuant to a general police policy requiring all police

[32] R. v. *Simmons*, (1988) 45 C.C.C. (3d) 296 (S.C.C.).

[33] *Ibid.*

[34] *Cloutier* (1990) 53 C.C.C. (3d) 257 (SCC) at pages 277-278.

[35] (1998) 126 C.C.C. (3d) 321 (Ont. C.A.).

officers to strip-search every person brought into the station in custody, regardless of the circumstances of the case or the individual. The Court held that the search was unreasonable and in violation of section 8 of the Charter. The Court stated that the strip search was not justified in law and was not incidental to an arrest. It found the breach was *"outrageous"* and *"flagrant"* and that it would shock the public. According to the Court, strip-searching *"is one of the most intrusive manners of searching" and "one of the most extreme exercises of police power."* Although the police can search incidental to an arrest, *"the degree of intrusion must be reasonable and in pursuit of a valid objective such as safety."*

The recent Supreme Court of Canada decision in *R. v. Golden*[36] reviews issues surrounding searches incidental to arrest and the manner in which such a search may be conducted. Mr. Golden was arrested following what police believed were drug transactions in a restaurant. He was taken to a stairwell where the police pulled down his pants and underwear and noticed a clear plastic wrap containing a white substance in the anal area. The police tried to retrieve it but the accused resisted. He was escorted back into the restaurant and patrons were told to leave. The accused was forced to lean over a table and his pants and underwear were lowered. He continued to resist police attempts to retrieve the plastic wrap and accidentally defecated–which did not dislodge the plastic wrap. The police retrieved a pair of rubber dishwashing gloves and removed the package while the accused was face-down on the floor. The accused was strip-searched again at the police station. The Supreme Court made the following statement regarding strip searches:

> *While the respondent and the interveners for the Crown sought to downplay the intrusiveness of strip searches, in our view it is unquestionable that they represent a significant invasion of privacy and are often a humiliating, degrading and traumatic experience for individuals subject to them. Clearly, the negative effects of a strip search can be minimized by the way in which they are carried out, but even the most sensitively conducted strip search is highly intrusive. Furthermore, we believe it is important to note the submissions of the ACLC and the ALST that African Canadians and Aboriginal people are overrepresented in the criminal justice system and are therefore likely to represent a disproportionate number of those who are arrested by police and subjected to personal searches, including strip searches... As a result, it is necessary to develop an appropriate framework governing strip searches in order to prevent unnecessary and unjustified strip searches before they occur.*[37]

In *Golden*, the Supreme Court of Canada found that the Crown had failed to prove that the strip search of the appellant was carried out in a reasonable manner. It was of the view that the evidence fell far short of establishing that a situation of exigency existed so as to warrant a strip search outside of the police station, particularly with the station two minutes away. Thus, the Court concluded that this was not a case involving an urgent and necessary need to conduct a strip search "in the field" for the purpose of preserving evidence.

---

[36] 2001 SCC 83.

[37] Ibid., para. 83.

The Supreme Court also cautioned against the use of force in conducting a search:

> *We particularly disagree with the suggestion that an arrested person's non-cooperation and resistance necessarily entitles police to engage in behaviour that disregards or compromises his or her physical and psychological integrity and safety. If the general approach articulated in this case is not followed, such that the search is unreasonable, there is no requirement that anyone cooperate with the violation of his or her Charter rights. Any application of force or violence must be both necessary and proportional in the specific circumstances. In this case, the appellant's refusal to relinquish the evidence does not justify or mitigate the fact that he was strip searched in a public place, and in a manner that showed considerable disregard for his dignity and his physical integrity, despite the absence of reasonable and probable grounds or exigent circumstances.* [38]

The importance of *Golden* is that the Supreme Court adopted a *"framework for the police in deciding how best to conduct a strip search incident to arrest in compliance with the Charter."* It set out the following questions:

1. *Can the strip search be conducted at the police station and, if not, why not?*
2. *Will the strip search be conducted in a manner that ensures the health and safety of all involved?*
3. *Will the strip search be authorized by a police officer acting in a supervisory capacity?*
4. *Has it been ensured that the police officer(s) carrying out the strip search are of the same gender as the individual being searched?*
5. *Will the number of police officers involved in the search be no more than is reasonably necessary in the circumstances?*
6. *What is the minimum of force necessary to conduct the strip search?*
7. *Will the strip search be carried out in a private area such that no one other than the individuals engaged in the search can observe the search?*
8. *Will the strip search be conducted as quickly as possible and in a way that ensures that the person is not completely undressed at any one time?*
9. *Will the strip search involve only a visual inspection of the arrestee's genital and anal areas without any physical contact?*
10. *If the visual inspection reveals the presence of a weapon or evidence in a body cavity (not including the mouth), will the detainee be given the option of removing the object himself or of having the object removed by a trained medical professional?*
11. *Will a proper record be kept of the reasons for and the manner in which the strip search was conducted?*

Because of the nature of drug-related offences and the fact that the substance is more easily concealed, it would appear that more intrusive searches may be allowed. The courts are certainly aware of the tactics used by offenders to conceal drugs and may be more willing to allow police conduct that would otherwise be unreasonable. It is clear from the decisions, however, that the more intrusive the search, the greater must be the justification and greater the constitutional protection.

---

[38] *Ibid.*, para. 116.

Schools

In R. *v. M. (M.R.)*,[39] in a majority decision, the Supreme Court of Canada has held that a student's reasonable expectation of privacy in the school environment is *"significantly diminished"* because school authorities are responsible for *"providing a safe environment and maintaining order and discipline in the school."* In the case of searches by school authorities (not the police), there is no requirement for a warrant, and the standard is reasonable belief. The school authority must not, however, be an agent of the police. The Court added that students must know *"that this may sometimes require searches of students and their personal effects and the seizure of prohibited items."* In the result, the Court held that the seizure of marijuana from a student searched during a school dance did not infringe his rights under section 8 of the Charter. While setting out the parameters for a reasonable warrantless search in such circumstances, it must be noted that the majority decision expressly limited its findings to the elementary or secondary school milieu, with "no consideration" having been given to a college or university setting.

Borders

Searches conducted by customs officers at the border are an example of reduced constitutional protections where the courts find that there is a lower expectation of privacy based on the context. In such cases, the standards established in *Hunter* may not apply.

Section 98 of the *Customs Act*[40] allows an officer to search a person who has just arrived in Canada within a reasonable time of the person's arrival, or a person who is about to leave, if the officer suspects on reasonable grounds that the person has hidden illegal items on his or her person. The Supreme Court of Canada has interpreted this standard as one of reasonable suspicion and not the higher standard of reasonable grounds.[41] A person about to be searched can request to be taken before a senior officer who will make a determination as to whether the search shall proceed.[42]

In R. v. *Simmons*,[43] the accused was required to submit to a strip search as the result of a customs officer's belief that she was carrying contraband. The Supreme Court's decision acknowledged Canada's right as a sovereign state to control both who and what crosses its boundaries. Even though the search power did not meet the standards that it had set out in *Hunter* (for example, prior authorization and reasonable grounds), the Court stated:

---

[39] [1998] 3 S.C.R. 393.
[40] S.C. 1986 c. 1.
[41] R. v. *Monney*, (1999) 133 C.C.C. 129 (S.C.C.).
[42] The *Customs Act* also contains many other provisions dealing with powers of customs officers. These are not discussed.
[43] (1988) 45 C.C.C. 296 (S.C.C.).

> *I accept the proposition advanced by the Crown that the degree of personal privacy reasonably expected at customs is lower than in most other situations. People do not expect to be able to cross international borders free from scrutiny. It is commonly accepted that sovereign states have the right to control both who and what enters their boundaries. For the general welfare of the nation the state is expected to perform this role. Without the ability to establish that all persons who seek to cross its borders and their goods are legally entitled to enter the country, the state would be precluded from performing this crucially important function. Consequently, travellers seeking to cross national boundaries fully expect to be subject to a screening process. This process will typically require the production of proper identification and travel documentation and involve a search process beginning with completion of a declaration of all goods being brought into the country. Physical searches of luggage and of the person are accepted aspects of the search process where there are grounds for suspecting that a person has made a false declaration and is transporting prohibited goods.*
>
> *In my view, routine questioning by customs officers, searches of luggage, frisk or pat searches, and the requirement to remove in private such articles of clothing as will permit investigation of suspicious bodily bulges permitted by the framers of ss. 143 and 144 of the* Customs Act*, are not unreasonable within the meaning of s. 8. Under the* Customs Act *searches of the person are not routine but are performed only after customs officers have formed reasonable grounds for supposing that a person has contraband secreted about his or her body. The decision to search is subject to review at the request of the person to be searched. Though in some senses personal searches may be embarrassing, they are conducted in private search rooms by officers of the same sex. In these conditions, requiring a person to remove pieces of clothing until such time as the presence or absence of concealed goods can be ascertained is not so highly invasive of an individual's bodily integrity to be considered unreasonable under s. 8 of the Charter.*
>
> *I also emphasize that, according to the sections in question: (i) before any person can be searched the officer or person so searching must have reasonable cause to suppose that the person searched has goods subject to entry at the customs, or prohibited goods, secreted about his or her person, and (ii) before any person can be searched, the person may require the officer to take him or her before a police magistrate or justice of the peace or before the collector or chief officer at the port or place who shall, if he or she sees no reasonable cause for search, discharge the person.*
>
> *In light of the existing problems in controlling illicit narcotics trafficking and the important government interest in enforcing our customs laws, and in light of the lower expectation of privacy one has at any border crossing, I am of the opinion that ss. 143 and 144 of the* Customs Act *are not inconsistent with s. 8 of the Charter.* [44]

It is noteworthy for our purposes that the Court mentioned the problems of controlling illicit narcotics trafficking as a factor in determining that the search was reasonable under section 8 of the Charter.

The fact that those travelling through customs have a lower reasonable expectation of privacy does not, however, diminish the obligation on state authorities to adhere to the Charter, even if the grounds prompting the search are reasonable and drugs are found as a result. Before any search, the inspectors must clearly explain to the subject his/her rights under the Charter – especially the prior right to consult a lawyer –

[44] *Ibid.*, at pages 320-321.

and the right to have the search request reviewed before complying with it, as provided in the *Customs Act.* In *Simmons*, the subject remained ignorant of her legal position because she had not properly been informed of her rights. As a result, the Supreme Court of Canada found that the search was unreasonable; even so, the evidence was not excluded because the customs officers had acted in good faith.

The Supreme Court of Canada has determined that section 98 of the *Customs Act*, authorizing searches for contraband "secreted on or about" the person, applies to contraband that a traveller has ingested. In *R.* v. *Monney*,[45] the Court concluded that a customs officer who has reasonable grounds to suspect that contraband has been ingested is authorized by the Act to detain the traveller in a "drug loo facility" until that suspicion can be confirmed or dispelled. Although such action amounts to a search for the purposes of section 8 of the Charter, the Court confirmed that *"the degree of personal privacy reasonably expected at customs is lower than in most other situations" and that the search in question was "reasonable for the purposes."*

The Court did indicate that the different levels of intrusion raise different constitutional issues (for example, by potentially requiring a higher standard than reasonable suspicion). The Court stated: *"the potential degree of state interference with an individual's bodily integrity for searches in the third category requires a high threshold of constitutional justification."*[46]

It is clear that the courts apply a lower standard of constitutional protection for searches at the border than elsewhere. As stated in *Monney*, *"decisions of this Court relating to the reasonableness of a search for the purposes of s. 8 in general are not necessarily relevant in assessing the constitutionality of a search conducted by customs officers at Canada's border."*[47]

Electronic surveillance

Because of the consensual nature of drug offences, police often resort to special investigative techniques to detect these crimes, including the use of electronic surveillance. The Supreme Court of Canada has stated that electronic surveillance constitutes a search for the purposes of section 8 of the Charter, and its decisions in this area have had a significant impact on the *Criminal Code* provisions dealing with such techniques. Because electronic surveillance is more invasive of privacy than actions under regular search warrants, more procedural safeguards are provided in the legislation. Although surreptitious interception is often used for drug offences, it can also be used for many other serious offences under the *Code* and other federal legislation.[48] The Solicitor General's 1998 report entitled *Annual Report on the Use of Electronic Surveillance* states the following with respect to the importance of electronic surveillance as an investigative tool:

---

[45] (1999) 133 C.C.C. 129 (S.C.C.).

[46] *Ibid.*, at page 152.

[47] *Ibid.*, at page 151.

[48] See *Criminal Code* section 183.

> *Electronic surveillance plays a crucial role in the battle against organized crime, especially with respect to the offence of drug trafficking. In curtailing the importation and distribution of illicit drugs in Canada, law enforcement agencies rely heavily upon the interception of private communications. Section III of this report demonstrates that the majority of authorizations granted by the courts allow for the use of electronic surveillance in relation to trafficking in a controlled substance. As in previous years, many of these authorizations were related to criminal conspiracies, crimes which are difficult for the police to detect, investigate and solve.*
>
> *...The use of electronic surveillance has led to a number of seizures of large quantities of drugs in Canada. These seizures reduce the amount of drugs available in streets and neighbourhoods, and assist in the prevention of crimes associated with drug abuse. Without this crucial tool, the ability of the law enforcement community to prevent crimes and ensuing social harm would be seriously hindered.*

Although it is clear that electronic surveillance is an effective investigative tool, it is also clear that it constitutes a dramatic infringement of the right to privacy. The Supreme Court of Canada stated the following:

> *The very efficacy of electronic surveillance is such that it has the potential, if left unregulated, to annihilate any expectation that our communications will remain private. A society which exposes us, at the whim of the state, to the risk of having a permanent electronic recording made of our words every time we opened our mouths might be superbly equipped to fight crime, but would be one in which privacy no longer had any meaning. As Douglas J., dissenting in United States v. White, supra, put it, at p. 756: "Electronic surveillance is the greatest leveller of human privacy ever known." If the state may arbitrarily record and transmit our private communications, it is no longer possible to strike an appropriate balance between the right of the individual to be left alone and the right of the state to intrude on privacy in the furtherance of its goals, notably the need to investigate and combat crime.*
>
> *This is not to deny that it is of vital importance that law enforcement agencies be able to employ electronic surveillance in their investigation of crime. Electronic surveillance plays an indispensable role in the detection of sophisticated criminal enterprises. Its utility in the investigation of drug related crimes, for example, has been proven time and again. But, for the reasons I have touched on, it is unacceptable in a free society that the agencies of the state be free to use this technology at their sole discretion. The threat this would pose to privacy is wholly unacceptable.*[49]

Because electronic surveillance is more invasive of privacy than are actions permitted under regular search warrants, more procedural safeguards are provided in the legislation. Similar rules apply to video surveillance.

The Supreme Court of Canada decisions rendered on 25 January 1990 in the *Duarte* and *Wiggins* cases had a significant impact on policing methods, particularly undercover investigations involving drug and morality offences. In *Duarte*,[50] the Court affirmed that electronic surveillance constitutes a search and seizure within the meaning of section 8. This only occurs, however, where a reasonable expectation of privacy

[49] R. v. *Duarte*, (1990) 53 C.C.C (3d) 1 (S.C.C.) at page 11.
[50] (1990) 53 C.C.C. (3d) 1 (S.C.C.).

exists. The Court said that unauthorized electronic surveillance and interception *"of private communications by an instrumentality of the state with the consent of the originator or intended recipient thereof, without prior judicial authorization, does infringe the rights and freedoms guaranteed by section 8."* Until then, it had been legal for the police to intercept such communications, as long as one of the parties to the conversation consented. It is now necessary for a judge to authorize such interception in the same way as interception of an entirely private conversation ("wiretapping") where neither party has given prior consent. The Court also required that there be reasonable and probable grounds, established on oath, to believe that there is evidence of an offence in the place to be searched. Suspicion would not satisfy this requirement.

In *Duarte*, the Supreme Court of Canada said that "the primary value served by section 8 is privacy," which it defined as *"the right of the individual to determine when, how, and to what extent he or she will release personal information."* Accordingly, *"one can scarcely imagine a state activity more dangerous to individual privacy than electronic surveillance and to which, in consequence, the protection accorded by s. 8 should be more directly aimed."* The Court took the position that it could no longer allow the police an "unfettered discretion ... to record and transmit our words" without prior judicial authorization because this widespread police practice represented an *"insidious danger"* to the *"very hallmark of a free society,"* namely, the *"freedom not to be compelled to share our confidences with others."* In *Wiggins*,[51] the use of "body pack" microphones by police was also found to be unconstitutional, for the reasons expressed in *Duarte*. The Duarte decision demonstrates that even if conduct is authorized by legislation, this does not mean that it is reasonable under section 8. The *Code* has since been amended to provide for prior authorization of consent interceptions.

With respect to surreptitious interceptions, a judge must ensure that: (1) the best interests of the administration of justice would be served; and (2) other investigative procedures (a) have been tried and have failed; or (b) are unlikely to succeed; or (c) the situation is urgent. In 2000, the Supreme Court of Canada in R. v. *Araujo*[52] interpreted the second requirement set out in the legislation. The Court indicated that the standard for branch (b) was not one of "efficiency" but rather "necessity." The test is: There must be, practically speaking, no other reasonable alternative method of investigation, in the circumstances of the particular criminal inquiry.

<u>Section 24</u>

Section 24(1) of the Charter provides a course of action for accused persons whose Charter rights have been infringed or denied. Under it, they can apply to a "court of competent jurisdiction" for the "appropriate and just" remedy. Section 24(2) allows a court to exclude evidence obtained in a manner that infringed or denied Charter rights, if admitting it into evidence *"would bring the administration of justice into*

---

[51] [1990] 1 S.C.R. 30.
[52] (2000) S.C.C. 65.

disrepute." The three primary factors to be considered are: (a) does the admission of the evidence affect the fairness of the trial; (b) how serious was the Charter breach; and (c) what would be the effect on the system's repute of excluding the evidence.

Some have criticized the way these factors are applied to drug-related offences. For example, Don Stuart stated the following:

> *The impression left by these recent Supreme Court and Ontario Court of Appeal rulings, especially in drug cases, is that these Courts seem generally determined not to exclude real evidence found in violation of section 8. These Courts tend to ratchet up the rhetoric respecting the third Collins factor about the seriousness of the offence and the effect on the repute of the system if the exclusion of reliable evidence were to result in acquittals. If this is the major reason for admitting the evidence, it points to an irony and inconsistency with the Stillman approach, in that the seriousness of the offence and reliability are* not *relevant factors when evidence is characterized as going to trial fairness. Canadian criminal trials under the Charter are no longer exclusively concerned with determining guilt or innocence and it betrays respect for the Charter to argue a return to the pre-Charter days where police conduct was not a material consideration. Particular abhorrence of drug offences may well have coloured consideration of the second Collins factor so that seriousness of the violation is unduly de-emphasised. The Courts, as guardians of the Charter, should be above the war against drugs. This one category of offences does not require special and reduced Charter standards.* [53]

The decision of whether the evidence should be excluded can be important; if courts are reluctant to exclude evidence, they may be sending conflicting messages to the police. Although their conduct will have been found to breach a person's Charter rights, there may be little incentive for the police to adhere to the limits imposed by the courts if the evidence is not excluded.

Entrapment and illegal activity

Entrapment and illegal police activity are both based on the doctrine of abuse of process.

Entrapment

In some cases, police forces use informers (including paid informers) or undercover police agents to obtain information about criminal offences. With consensual offences such as those related to drugs, infiltrating a group and acting as a consensual participant is often the only way for the police to obtain evidence of an offence. They are generally there to observe the suspect and, in some instances, may afford the suspect an opportunity to commit an offence The police must ensure that the actions of the informer or the undercover agent do not go too far. When police actions are excessive, the accused may attempt to rely on the doctrine of entrapment. Although police tactics intended to provide a person with the opportunity to commit

---

[53] Stuart, D. (1999) "The Unfortunate Dilution of Section 8 Protection," *Queens Law Journal*, Volume 25, Number 1, page 68.

an offence and illegal police activities are not limited to drug offences, it is fair to state that these tactics are probably much more prevalent in investigations of these types of offences.

The leading case in Canada on entrapment is the Supreme Court of Canada's decision in R. v. *Mack*.[54] Lamer J., as he then was, delivered the unanimous judgement of the Supreme Court of Canada. He explained that entrapment is not a substantive defence (such as necessity or duress) and indicated that the rationale for this defence is not a lack of culpability in the accused (because the essential elements of the offence will generally be present). Rather, the rationale is based on the need for the Court "to preserve the purity of the administration of justice" and to prevent an abuse of the judicial process. Thus, entrapment is based on the common law doctrine of abuse of process. According to Lamer J., entrapment occurs when the conduct of the police exceeds acceptable limits. This is the case in the following circumstances:

- The authorities provide a person with an opportunity to commit an offence without acting on a reasonable suspicion that this person is already engaged in criminal activity or pursuant to a *bona fide* inquiry; or
- Having a reasonable suspicion or acting in the course of a *bona fide* inquiry, the police go beyond providing an opportunity and induce the commission of an offence.

To establish entrapment, the accused is required to demonstrate only that one of the two branches of the test has been met. If successful, the remedy is a stay of proceedings.

According to the guidelines set out by the Supreme Court of Canada, the police are required to have a reasonable suspicion that the accused is already engaged in criminal activity, or must be acting pursuant to a *bona fide* inquiry. The rationale for requiring reasonable suspicion is *"because of the risk that the police will attract people who would not otherwise have any involvement in a crime and because it is not a proper use of the police power to simply go out and test the virtue of people on a random basis."*[55]

In determining whether police conduct goes further than providing an opportunity, a court will assess the following non-exhaustive list of factors:

- The type of crime being investigated and the availability of other techniques for the police detection of its commission;
- Whether an average person, with both strengths and weaknesses, in the position of the accused would be induced into the commission of a crime;
- The persistence and number of attempts made by the police before the accused agreed to commit the offence;

---

[54] (1988) 44 C.C.C. (3d) 513 (S.C.C.).
[55] *Ibid.*, at page 560.

- The type of inducement used by the police, including deceit, fraud, trickery or reward;
- The timing of the police conduct, in particular whether the police instigated the offence or become involved in ongoing criminal activity;
- Whether the police conduct involves an exploitation of human characteristics such as the emotions of compassion, sympathy and friendship;
- Whether the police appear to have exploited a particular vulnerability of a person such as a mental handicap or a substance addiction;
- The proportionality between the police involvement, as compared to that of the accused, including an assessment of the degree of harm caused or risked by the police, as compared to the accused, and the commission of any illegal acts by the police themselves;
- The existence of any threats, implied or express, made to the accused by the police or their agents; and
- Whether the police conduct is directed at undermining other constitutional values.[56]

The Supreme Court of Canada stated that the claim of entrapment is a very serious allegation against the state, and that the state must be given substantial room to develop techniques which assist in its fight against crime in society. It is only when the police and their agents engage in conduct which offends basic values of the community that the doctrine of entrapment should apply. The Court indicated that a stay should be entered only in the *"clearest of cases."*[57]

In *Mack*, the Supreme Court of Canada stated that with respect to the crime of drug trafficking, the state must be given substantial leeway. This offence *"is not one which lends itself to the traditional devices of police investigation."* The Court added that it is a *"crime of enormous social consequence which causes a great deal of harm in society generally."* The Court concluded *"this factor alone is very critical."*[58]

Although the Supreme Court of Canada stated in *Mack* that random virtue-testing will not be permitted because there is a risk of attracting innocent individuals into the commission of an offence, it does make an exception to the requirement to have reasonable suspicion with respect to the individual in the case of a *bona fide* investigation related to an area where it is reasonably suspected that criminal activity is taking place.

It is clear that such an exception can apply to known locations of drug trafficking. An example of this can be seen in *R. v. Barnes.*[59] The accused was charged with a number of offences, including trafficking in cannabis. An undercover police officer had approached the accused and his friend because they generally fitted the description of persons who may possess and sell drugs. After a short conversation, the accused agreed

[56] *Ibid.*, at page 560.
[57] *Ibid.*, at page 567.
[58] *Ibid.*, at page 69.
[59] (1991) 66 C.C.C. (3d) 1 (S.C.C.).

to sell hashish to the undercover agent. The place where the arrest took place (a six-block pedestrian mall) was a well-known area where trafficking occurred, and the police were conducting what are known as "buy-and-bust" transactions. The accused relied on the defence of entrapment.

The Supreme Court of Canada reiterated the circumstances when entrapment occurs. Because in this case the police did not have reasonable suspicion of the accused's involvement in unlawful drug-related activity, its conduct would amount to entrapment unless it was part of a *bona fide* inquiry. Thus, although the basic rule is that the police may only present the opportunity to commit an offence to a person for whom they have a reasonable suspicion that they are already engaged in criminal activity, there is an exception where the police conduct is part of a *bona fide* investigation directed in an area where it is reasonably suspected that criminal activity is occurring. If the location is defined with *"sufficient precision,"* the police may present any person associated with the area with the opportunity to commit the particular offence. In these circumstances, the police conduct would not be considered to be random virtue-testing.

In summary, the key issue with respect to entrapment is whether the police had reasonable grounds or suspicions to target an individual or were acting pursuant to a *bona fide* inquiry. In addition, even if the first branch of the test is satisfied, one must consider whether the police conduct went beyond providing an opportunity by determining whether the tactics used by the police were designed to induce an average person into the commission of an offence. It is important to note, however, that with respect to entrapment the *"fact situations can vary enormously, which is why, although the general principles are beginning to emerge, their application is not always easy and can lead to disagreement."*[60] The courts have indicated that each case must be determined on its own facts, making it difficult to provide more precise rules regarding police conduct.

Illegal activities

As has been discussed, as criminal offenders become more sophisticated, the police have adopted new investigative tools in an attempt to keep pace (including cases where police officers have breached the law while in the performance of their duties). This occurs in drug investigations, for example, when police conduct buy-and-bust operations and reverse sting operations. The use of illegal police activity to combat crime raises the issue of whether such conduct leads to an abuse of process such that a stay of proceedings will be granted. The Supreme Court of Canada has stated that illegal police activity does not automatically amount to an abuse of process. The legality of police actions is but a factor to be considered, "albeit an important one." Although the issue of illegal police activity is important, it has less of an impact on the

[60] Mewett, A.W. and S. Nakatsuru, (2000) *An Introduction to the Criminal Process in Canada*, Fourth Edition, Carswell, page 180.

enforcement of drug legislation. The reason is that the drug legislation provides police immunity for activities such as buy-and-bust operations and reverse sting operations.[61]

The leading case with respect to illegal police activities is R. v. *Campbell.*[62] The police in this case had conducted a reverse sting operation in which undercover officers portrayed themselves as large-scale hashish vendors. The accused argued that the police conduct was illegal because they had committed the offence of trafficking themselves (the CDSA and the exemption it provides for such police conduct having not yet been passed). They added that this amounted to an abuse of process.

According to the Supreme Court of Canada, the police are not immune from criminal liability for acts committed in the course of an investigation, unless this is authorized by legislation. The Court added that the issue should be left to Parliament: *"If some form of public interest immunity is to be extended to the police to assist in the 'war on drugs,' it should be left to Parliament to delineate the nature and scope of the immunity and the circumstances in which it is available…"*[63] Where alleged illegal police activity is authorized within the legislative scheme, there is no abuse of process issue. The Supreme Court of Canada added, however, that illegal police activity does not automatically amount to an abuse of process. The legality of police actions is but a factor to be considered, "albeit an important one."

Although this decision may have had a significant impact on general law enforcement in Canada, the impact was less severe in the case of drug enforcement. This is because drug legislation was amended to allow police officers to conduct the type of activities that were at issue in *Campbell.*

The CDSA proscribes various activities such as possession, trafficking and manufacturing of drugs, while allowing various regulatory exceptions, for example the importation by licensed dealers and the sale by pharmacists. The Act also allows for the making of regulations dealing with enforcement matters such as exempting police officers from application of the Act on such terms and conditions as specified in the regulations. In addition, the Act allows for the making of regulations *"that pertain to investigations and other law enforcement activities conducted under this Act by a member of a police force and other persons acting under the direction and control of a member."* Thus, the regulations provide a legal framework for specialized enforcement techniques (including buy-and-bust, and sting operations) and set out the parameters for such activities. The police rely on these regulations for protection against prosecution.

Section 3 of the *Narcotic Control Regulations* authorizes members of police forces to possess narcotics where such *"possession is for the purposes of and in connection with such employment."* In addition, the CDSA *(Police Enforcement) Regulations* exempt police officers from the offences of trafficking, importation or exportation and production. The regulations set out the eligibility requirements for the exemption. Different rules apply

[61] Illegal activities by a police officer also raise the issue of whether the police officer may be liable to prosecution. The issue is beyond the scope of this paper.

[62] (1999) 133 C.C.C. (3d) 257 (S.C.C.).

[63] *Ibid.*, at page 282.

depending on the source of the drugs. At all times, the individual must be an active member of a police force and must be acting in the course of his or her responsibilities for the purposes of the particular investigation.

Thus, special immunity for police officers is set out in the CDSA. Canadian criminal legislation has recently been amended to provide a general exemption from criminal liability for police officers. The legislation provides police with protection from criminal liability for certain otherwise illegal acts committed during the course of a *bona fide* investigation or other law enforcement duties, as long as certain conditions are met.[64]

Conclusion

Clearly, Parliament and the courts have recognized that, as criminals become more sophisticated, the police must be given more sophisticated tools to fight them. In addition, they generally view the illegal drug trade as a serious challenge. Courts often mention the sinister nature of the drug trade and the impact it has on society in rendering their decisions. They may be influenced by these concerns in determining where to draw the line with respect to police conduct. They recognize the difficult job police have and are often willing to grant them "considerable latitude." An example of this attitude is the following statement by the Supreme Court of Canada with respect to the selling of drugs: *"It is a crime that has devastating individual and social consequences. It is, as well, often and tragically coupled with the use of firearms. This crime is a blight on society and every effort must be undertaken to eradicate it."*[65] In another case, the following was stated: "… *this Court must also consider the societal interest in law enforcement, especially with regard to the illicit drug trade. This pernicious scourge in our society permits sophisticated criminals to profit by inflicting suffering on others.*"[66] However, the police have not been given "carte blanche" to do what they want to solve a crime. Their activities are scrutinized so as to ensure that their conduct does not shock the community and in any way detract from the fairness of an accused's trial.

STATISTICS

The following sections will review key criminal statistics related to enforcement of illicit drug legislation. This information must be carefully interpreted. It is generally thought that police-reported crime statistics are much more a reflection of police activity than actual societal changes, particularly in the case of consensual type offences.

---

[64] SC 2001, Chapter 32.
[65] R. v. *Silveira*, (1995) 97 C.C.C. (3d) 450 at page 496.
[66] R. v. *Grant*, (1993) 84 C.C.C. (7d) 173.

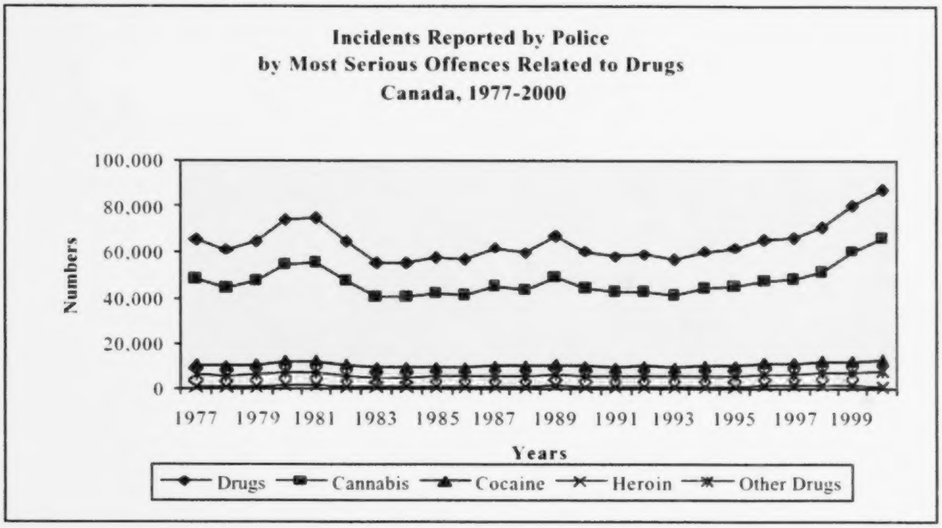
As in many other drug related areas, Canadian statistics are fairly weak–for example, other than fairly basic information, it is very difficult if not impossible to identify some of the essential characteristics of individuals entering the criminal justice system.

Reported incidents[67]

Reported incidents are incidents that come to the attention of the police and are captured and forwarded to the Canadian Centre for Justice Statistics according to a nationally approved set of common crime categories and definitions. Thus the actual number of drug offences would be much higher, since it can be assumed that most drug offences do not come to the attention of police. As with other consensual types of offence, it is impossible to determine accurately the amount of illegal activity. In addition, the survey counts only the most serious offence committed in each criminal incident, which consequently underestimates the total number of drug-related incidents, particularly offences with less severe penalties. The number of reported incidents should also not be confused with the number of charges that are laid by the police. Because police have wide discretion in whether to lay a charge, it is clear that the number of charges will be lower than the total reported incidents.

The figure below shows trends in the number of incidents reported by police according to the most serious crime. It reveals that, from 1983 to 1995, incidents related to drug offences were relatively stable, hovering around 60,000 per year. However, from 1995 to 2000, there was an increase of approximately 50%, with the number of reported incidents reaching nearly 88,000. In 2001, the number reached 91,920, an increase of 3.3% in relation to the previous year.

[67] The Canadian Centre for Justice Statistics warns that crime statistics may be influenced by many factors, including: reporting by the public to the police; reporting by the police to the Canadian Centre for Justice Statistics; the impact of new initiatives such as changes in legislation, police or enforcement practices; and social, economic and demographic changes.



Most of the increase in recent years can be attributed to cannabis-related offences. In 2001, these increased by 5.5% in relation to the previous year. These offences account for the majority of all drug-related offences in Canada. In 2001, cannabis-related offences accounted for 71,624 of reported incidents, **almost 77% of all drug-related incidents**. Of those 71,624 offences, 70% were for possession, 16% for trafficking, 13% for cultivation, and 1% for importation.[68] This means that **approximately 54% of all reported drug-related offences are for the possession of cannabis**. The following are reported incident rates per 100,000 people for offences related to cannabis, cocaine and all drugs.

Selected drug offences per 100,000, Canada 1994-2001

	1994	1995	1996	1997	1998	1999	2000	2001
Cannabis	138	148	157	160	168	197	215	227.22
- possession	97	103	110	108	115	130	147	
Cocaine	42	38	37	38	40	39	42	39.4
Total all drugs	207	208	217	222	235	263	286	295.7

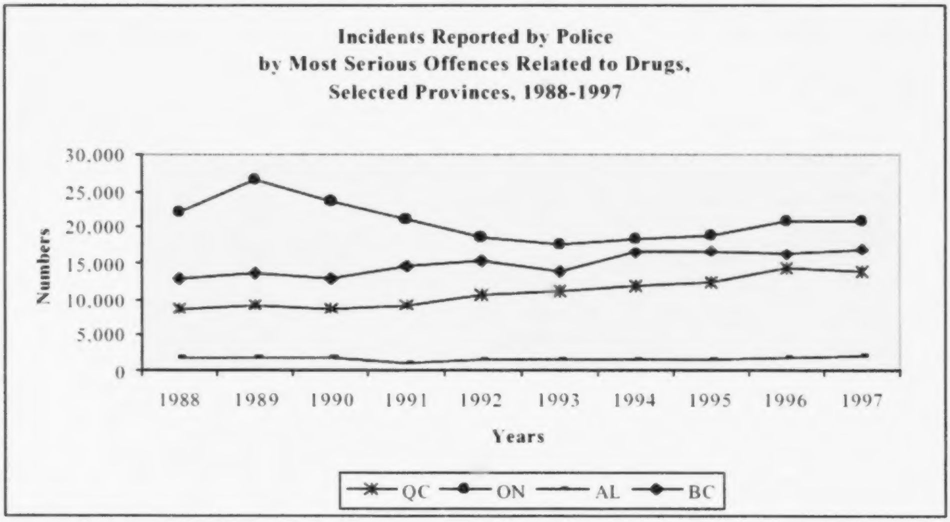
From 1991 to 2001, the percentage change in rate per 100,000 people for cannabis-related offences is +91.5; for cocaine-related offences, –31.5; for heroin-related offences, –36.1; and for other drugs, +15.0. **This means that, based on the**

[68] Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Crime Statistics in Canada - 2001, Catalogue no. 85-002-XIE Vol. 22, no. 6, page 11.

same population, reported cannabis-related offences have almost doubled in the last decade.

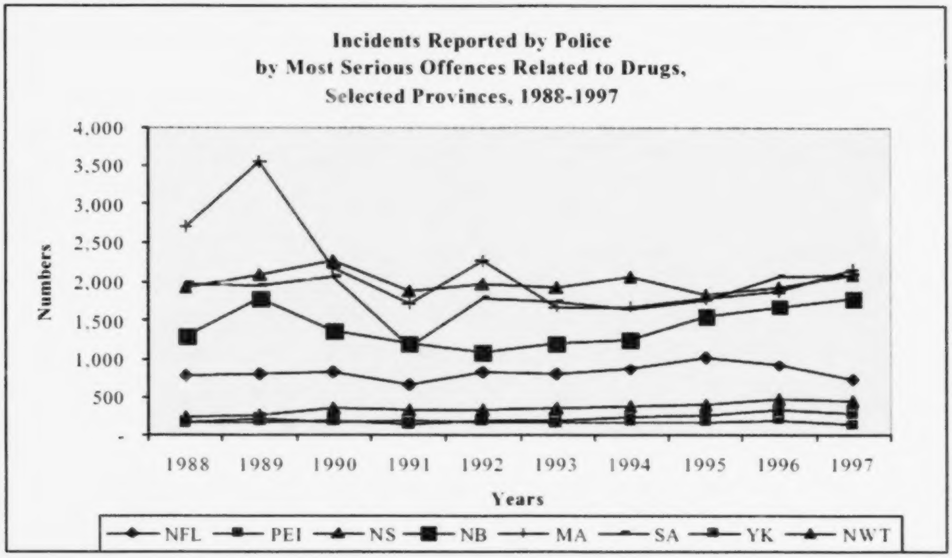
In recent years, the cultivation of cannabis, particularly in British Columbia, has raised concerns. This type of offence has also seen a significant increase over the past decade: from a rate of 7 incidents per 100,000 people in 1990 to 29 in 2001.[69] A recent report indicates that in British Columbia, the number of growing operations is increasing by an average of 36% per year and average size is increasing at a rate of 40% per year. The report adds that the vast majority of cases coming to the attention of the police in British Columbia do so as a result of public complaints, meaning that the increase in cases is not due to increased proactive police enforcement.[70]

The two figures that follow provide information on the location of reported incidents from 1988 to 1997. Not surprisingly, the most populated provinces are at the top, with Ontario in the lead followed by British Columbia, Quebec and Alberta.



[69] *Ibid.*

[70] Plecas, D., et. alii., (2002) *Marihuana Growing Operations in British Columbia – An Empirical Survey (1997-2000)*, Department of Criminology and Criminal Justice – University College of the Fraser Valley and International Centre for Criminal Law Reform and Criminal Justice Policy.



A better indication of the level of crime in a province, however, is a calculation based on rates per 100,000 population. British Columbia has historically had the highest provincial rate of drug crime in the country.[71] For example, in 2001, the rate was 563.5 incidents per 100,000, almost double the national figure of 295.7. The rates for the other provinces and erritories are as follows: Newfoundland and Labrador–173.1; Prince Edward Island–192.0; Nova Scotia–218.3; New Brunswick–346.9; Quebec–262.1; Ontario–256.1; Manitoba–215.9; Saskatchewan–278.4; Alberta–235.3; Yukon – 478.5; Northwest Territories–597.2; and Nunavut–806.1. It is obvious that the level of drug-related crime varies considerably from one province and territory to another.

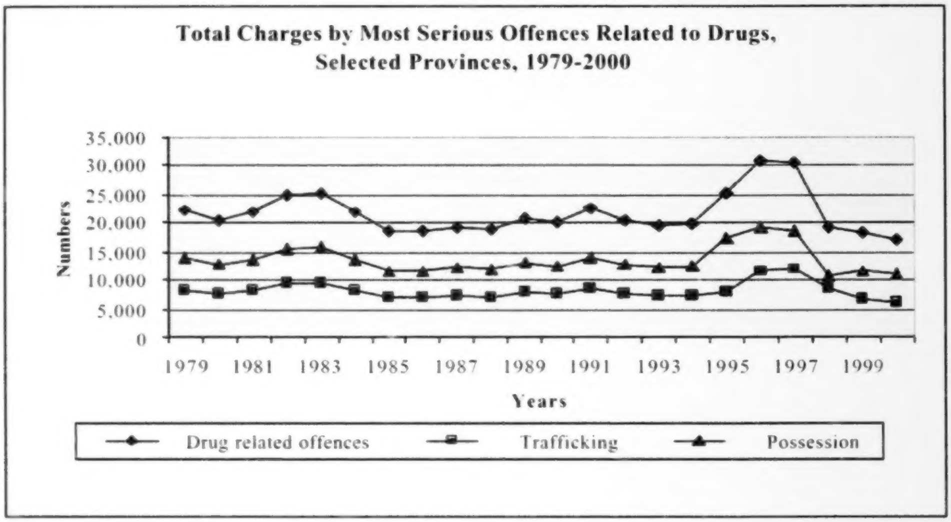
Charges

From the available data presented in the following figure, it would seem that trafficking and possession charges for drug-related offences have declined noticeably since 1997. It should be remembered that the number of reported incidents (discussed previously) is not equivalent to the number of charges that are laid by the police. In some cases, the police will report a drug incident to Statistics Canada but will decide not to charge the offender. The wide discretion given to police can lead to serious concerns regarding the enforcement of the legislation. These concerns are discussed later in this chapter. The reader should be aware that this figure does not include data

[71] It should be noted that in 1997 the rate in both Yukon and Northwest Territories was even higher than in British Columbia.

from three provinces (New Brunswick, Manitoba and British Columbia) and from one territory (Nunavut). In addition, data from certain courts in Quebec are not included.[72]

Because data from three provinces are not included–in particular, British Columbia–the actual number of drug charges in Canada was actually much higher than the figure suggests. As was previously explained, British Columbia has, in the past, consistently reported the highest rate of drug crime.



Statistics from 1997 show, however, that with respect to charging drug offenders, British Columbia is more lenient than other provinces:

> *Among provinces and territories, police departments in British Columbia reported the lowest charge rate (47%) for drug offences. Only 35% of cannabis incidents and 36% of "other drug" incidents resulted in charges, compared to 79% and 81% for all the other provinces combined.*[73]

For example, Superintendent Ward Clapham of the Richmond RCMP indicated that, for possession of marijuana under 30 grams, only 40 people were charged out of 700 reported cases in the year 2000; and in 2001, only 30 people were charged out of 605 reported cases. Once again, it is clear that the enforcement of the legislation varies considerably from one area of the country to another.

With respect to cannabis offences in 2001, the male population was much more likely to be charged with an offence. For both youths (12 to 17) and adults, 88% of the

---

[72] Also, the data prior to 1995 are based on approximations made from the average distribution of charges during the period covering the years 1995 to 2000.

[73] Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Illicit Drugs and Crime in Canada, Catalogue no. 85-002-XIE, Vol. 19, No. 1, page 5. In this case, "other drugs" means: 1) illegal drugs other than cannabis, cocaine or heroin, and 2) controlled drugs.

people charged with cannabis offences are male.[74] In addition, while adults are much more likely to be charged than youths, 18% of cannabis-related charges relate to youths.[75]

While the previous figure seems to indicate that there were fewer than 20,000 drug-related charges in 1999, the Auditor General's 2001 report indicates that during that year, just under 50,000 people were charged with drug offences under the CDSA (in cases where the most serious offence was drug-related). One of the drawbacks of recording offence statistics according to the most serious offence is that this leads to severe underreporting of offences, particularly offences with less severe penalties. In the hierarchy of criminal offences (of which there are 152), marijuana offences are ranked as follows: importation or exportation– 44; trafficking of more than 3,000 grams–46; production–52; trafficking of 3,000 grams or less–59; possession of more than 30 grams–120; and possession of 30 grams or less--121.

Of the approximately 50,000 drug-related charges laid in 1999, cannabis was involved in 70% of the charges. **In 43% of the drug-related cases (21,381), the charge was for possession of cannabis.** Overall, 54% of the drug offences were for possession. Since the number of reported incidents has continued to climb, one can only assume that today even more people are being charged with drug offences, particularly cannabis offences.

With over 34,000 charges per year for cannabis-related offences and with over 21,000 charges per year for possession of cannabis, can one conclude that police are actively seeking out cannabis possession offences? After reviewing the evidence, we do not believe this to be the case. Nonetheless, over 21,000 people per year enter the criminal justice system in cases where their most serious offence was that of possession of cannabis. It bears repeating that these statistics are based on the most serious offence in a given incident.

Several reasons were advanced to explain the high number of possession offences. Those enforcing the CDSA stated that they do not actively seek out such offences, but rather they are discovered in the normal course of their duties. This was repeated time and time again. While we do not doubt the sincerity of these statements, in certain cases–as will be discussed below–police tactics can be questioned. In addition, we were told that while the offence of trafficking, if it occurs over a period of time, is recorded as one offence–the continuing offence rule–this rule does not apply to possession offences.

Concerns

While there may be valid reasons for the high incidence of possession charges, many have raised serious concerns with respect to the discretion used by the police in

[74] Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Crime Statistics in Canada - 2001, Catalogue no. 85-002-XIE, Vol. 22, No. 6, page 19.
[75] *Ibid.*

regard to drug-related possession charges – in particular, cannabis possession cases. As mentioned earlier, the number of reported incidents and the charge rate vary considerably from province to province.

The uneven application of the drug legislation in the various provinces, even within the same province, raises serious concerns. Mr. Kash Heed from the Vancouver Police Department indicated that small-scale possession of any drug in Vancouver is virtually unenforced by the police department unless there are aggravating circumstances. Their focus is on those who profit–traffickers and producers. He added that the number of prosecutions in British Columbia for cannabis possession is quite small in comparison to other provinces. He concluded that total prohibition had "resulted in costly enforcement, alienation of groups of people, discriminatory enforcement, little deterrence in supply, and minimal deterrence of use." Heed added that, even in British Columbia there are discrepancies–centres outside of Vancouver having higher rates of prosecution for possession of cannabis than does the City of Vancouver.

We have estimated that approximately 2.5 million people in Canada used cannabis in the last year. In 1999, 21,381 people were charged with the possession of cannabis. This means that only 0.85% of cannabis users were actually charged with possession. It is also important to remember that of the number of people who used cannabis in the last year, many would have used it more than once. As a result, the actual chance of being charged for possession of cannabis in relation to the actual number of offences is in all likelihood much lower than 1%. This certainly raises concerns regarding fairness. In addition, both the effectiveness of the legislation and any deterrent effect it may have are seriously in doubt.

So what are the potential consequences of uneven enforcement of the legislation and unfettered discretion as to whether or not to proceed with laying a charge? Marie-Andrée Bertrand, referring to a paper prepared by Nicolas Carrier[76] stated the following:

> *A recent qualitative study of members of the Montreal Urban Community Police Department underscores the ambivalence and confusions of frontline police officers and their varied reactions to the "drug problem." The extent of the problem is perceived quite differently depending on the officers in question and the neighbourhoods they patrol. In the minds of some, particularly in the case of young drug users and "exchangers", although "the law is the law" and must undoubtedly be enforced, drug possession and use do not really concern the police. The prohibition is simply not enforceable. It is impossible to determine cases of possession in the absence of search and seizure powers, except "on a hunch" or in arresting suspects for other "crimes". Once possession cases and drug deals in public places are discovered either by accident or in the course of investigating other offences, police officers react in various ways depending on their professional aspirations. Those seeking promotion and specialization (who want to join the drug or victimless crimes squads) pass the information along to the appropriate*

[76] Carrier, N. (2000) *Discours de patrouilleurs montréalais sur la détection de l'infraction de possession de drogues prohibées.* Mémoire de maitrise. École de criminologie, Université de Montréal.

divisions. Patrolmen who intend to remain patrolmen close their eyes or question suspects to obtain trafficking information in exchange for promises of immunity, or else take substances abusers to treatment services, call the parents of a minor, etc. [77]

The uneven application of the legislation is one of our greatest concerns, for a variety of reasons. First, there is the danger that this can lead to discriminatory enforcement, where certain people are more likely to be charged than others because of their personal characteristics. While current national statistics do not allow such an analysis, there is some evidence that the law is applied discriminatorily.

The Carrier paper discussed above was the result of interviews with 21 Montreal area patrol officers. It discusses the difficulties of detecting possession offences due to the lack of a "victim," the discreetness of the offences and the constitutional limits on unwarranted searches. The paper explains that a police officer's actions depend on several factors, such as how serious the officer perceives the drug problem to be and what are the officer's career aspirations–those wanting promotions respond more proactively to drug offences than those wishing to remain as patrol officers, who tend to be more reactive. Police are generally frustrated by the limits imposed on searches.

So how do they go about detecting possession offences? The officers indicated that most possession offences are detected when a person is stopped for another criminal matter–the arrest allowing an officer to conduct a search of the person. On rare occasions, officers detected the offence when a person openly flouted the law.

Of note, officers also indicated that certain people attracted their attention and some indicated that there are "signs" which lead them to believe that people are in possession of illegal substances. With respect to people in cars, the following factors were mentioned: the appearance of passengers in a vehicle; the vehicle's model and value; the person's driving habits; and a computer check of the licence plate indicating that the owner had a criminal record. Officers are allowed to stop people to ensure they have the proper documentation, and this may lead to the discovery of an offence that would result in a search. With respect to pedestrians, the following factors were mentioned: the person is known as a drug user; physical appearance; the person's activities; associating with other "suspects"; and association with dwellings suspected for trafficking. Certain officers indicated that questioning such suspects can lead to an arrest–for example, an outstanding warrant of arrest–and a search. Officers also indicated that on occasion they selectively applied municipal by-laws and other provincial legislation in order to obtain a person's name, after which the person can be investigated. If a person refuses to give his or her name, the person may be arrested and searched. Officers also indicated they had used techniques to "go fishing." While the evidence would not be admissible in court, in certain circumstances it allowed the

[77] Voir aussi la discussion qu'en fait M. Guy Ati-Dion lors de son témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 29 octobre 2001, fascicule 8, pages 73-74.

officer to obtain information from the person in exchange for "not laying a charge," or allowed the officer to seize the illegal substance.

While this study is of limited scope, it does provide an indication of how police discretion in enforcing drug legislation may lead to discrimination based on factors such as a person's appearance.

Another concern is the danger of alienating certain groups of society. Those targeted by enforcement may lose respect for police and the criminal justice system in general. Inconsistent legal responses are likely to create an atmosphere that brings the administration of justice into disrepute. As Parliamentarians, we find this unacceptable.

Finally, there is the basic issue of fairness and justice. No one seems able to explain why some people are charged and others are not. It is not surprising that this legislation faces such fierce criticism.

Customs Act - fines

In general, when one thinks of drug enforcement, one thinks of charges laid by police under the CDSA and seizures made by them. Other legislation can be applied in certain circumstances, however. For example, the *Customs Act* allows for the seizure of prohibited goods and also of vehicles used in contravention of that act. In this case, a civil "penalty" may be imposed against the importer, because a Customs officer may return the vehicle to the importer only upon payment of the assessed monetary penalty. The penalty is based on the quantity of drugs found.

Amount	Marihuana	Hashish	Hashish oil	Controlled drugs	Hallucinogens	Cocaine Opiates
$220	over 8 grams not over 15 grams	over 2 grams not over 4 grams	over 1 gram or less	over 10 pills not over 20 pills	over 1 dosage not over 4 dosages	1 gram or less $400
$440	over 15 grams not over 30 grams	over 4 grams not over 8 grams	over 1 gram not over 2 grams	over 20 pills not over 40 pills	over 4 dosages not over 8 dosages	
$550	over 30 grams not over 60 grams	over 8 grams not over 16 grams	over 2 grams not over 4 grams	over 40 pills not over 60 pills	over 8 dosages not over 12 dosages	
$660	over 60 grams not over 100 grams	over 16 grams not over 24 grams	over 4 grams not over 6 grams	over 60 pills not over 80 pills	over 12 dosages not over 16 dosages	
$770	over 100 grams not over 150 grams	over 24 grams not over 32 grams	over 6 grams not over 8 grams	over 80 pills not over 110 pills	over 16 dosages not over 20 dosages	
$880	over 150 grams not over 200 grams	over 32 grams not over 40 grams	Over 8 grams not over 10 grams	over 110 pills not over 140 pills	over 20 dosages not over 24 dosages	
$990	over 200 grams not over 250 grams	over 40 grams not over 46 grams	Over 10 grams not over 12 grams	over 140 pills not over 160 pills	over 24 dosages not over 28 dosages	
$1100	over 250 grams not over 300 grams	over 46 grams not over 56 grams	Over 12 grams not over 14 grams	over 160 pills not over 180 pills	over 28 dosages not over 32 dosages	

For amounts in excess of the above stated sums:

over 300 grams: $4 for each addi-tional gram	over 56 grams: $20 for each additional gram	over 14 grams: $70 for each additional gram	over 180 pills: $8 for each addi-tional pill	over 32 dosages: $40 for each addi-tional dosage	over 1 gram: $400 for each gram

The CCRA will also arrest the importer, under the authority of the *Customs Act*, for smuggling goods into Canada, that are prohibited, restricted or controlled by the Act or by any other Act of Parliament (for example, the CDSA). Once the CCRA has seized the drugs and made an arrest, the responsible police force is contacted and will decide whether or not to proceed and lay charges. As will be discussed later, in some cases, the CCRA has entered into Criminal Charge Agreements with police forces. The Crown Attorney will then decide whether or not to prosecute, based on case-by-case specifics.

Under section 6 of the CDSA importing drugs, except as authorized under the regulations, is an offence regardless of quantity. Therefore, in the case of importing, there is no "threshold" in the CDSA below which a lesser sentence or fine can be imposed. However, if the amount imported is of a quantity normal for personal use, rather than resale, the Crown may choose to prosecute for possession rather than importing.

The CCRA in Windsor has a Criminal Charge Agreement with the Windsor RCMP which sets out guidelines for criminal prosecution for border seizures. The amounts are to be used only as a guide, but generally a person will not be charged by the RCMP for importation of less than 50 grams of marijuana, less than 20 grams of

hashish or less than 15 grams of hash oil. In these cases, enforcement will be done under the *Customs Act.* From 1996 to 2001, almost 99% of the 4,055 marijuana seizures in the Southern Ontario region were for less than 50 grams.

SEIZURES

The following table provides information on seizures made by the RCMP, CCRA, Sûreté du Québec, Ontario Provincial Police and the municipal police forces of Montreal, Laval and Toronto.

Drugs Seized in Canada: 1993–2001

	1993	1994	1995	1996	1997	1998	1999	2000	2001
heroin	153	85	128	83	95	105	88	168	74
cocaine	2,731	7,915	1,544	3,110	2,090	2,604	1,116	1,851	1,783
ecstasy				1,221	10,222	68,496	400,000	2,069,709	1,871,627
marihuana (kg)	7,314	6,472	5,500	17,234	50,624	29,598	23,829	21,703	28,746
marihuana (plants)	238,601	288,578	295,999	675,863	689,239	1,025,808	954,781	1,102,198	1,367,321
hashish	56,721	36,614	21,504	25,155	6,118	15,924	6,477	21,973	6,677
liquid hashish	669	659	663	805	824	852	434	1,240	397

(Weights in kilograms; Ecstasy in dosage units)

According to Professor Steve Pudney, Public Sector Economics Research Centre, Department of Economics, Leicester University, "seizure data provide the most direct information on availability of drugs even though drugs seized are not contributing to the available supply."[78] If one looks at RCMP drug seizure trends, however, it becomes obvious that the data must be used cautiously, because the number of interceptions or the amount seized in one year is not necessarily a true indicator of an increase or decrease in the drug situation. Rather, it is an indication of the impact of active and passive policing.

> *Seizures are likely to be passive in the sense that there is a more or less constant seizure rate achieved by routine monitoring and investigation. The greater the amount of drugs entering the market, the greater the background level of seizures, on a purely statistical basis. Passive seizures are thus a positive*

[78] Appendix B. 'Referee's Comments.' In Bramley-Harker (2001) *Sizing the UK market for illicit drugs.* London: Home Office. RDS Occasional Paper no 74.

> *indicator of the size of the market. However, drug policing also has active aspects. Investigations based on criminal intelligence often lead to the closing down of pipelines of supply and the removal of significant quantities of the product from the domestic market. Seizures of this type are negatively related to market size in the sense that a large seizure, rather than being an indicator of supply growth, is a cause of supply contraction. When these two aspects are present, it is difficult to draw any clear conclusion about supply from information on seizures.*[79]

While passive seizures may indeed be a positive indicator of the size of the drug market, one must remember that passive seizures may also be somewhat inaccurate, because Canada's vast borders and coastline make it difficult for Canadian officials to make consistent interceptions and seizures each year. Importers continually find new ways of avoiding authorities by means of different ports of entry, as well as larger, infrequent shipments or vice versa.

Despite these problems with seizure data, the trends indicate that the seizures of cannabis, both in kilos and plants, have seen a fairly significant increase in the last few years, particularly when compared to seizures relating to cocaine and heroin.

What is clear from the seizure data is that police have, in recent years, placed increased emphasis on marijuana cultivation offences. In 1993, police seized fewer than 250,000 marijuana plants, while seizures in 2001 totalled more than 1,350,000 plants. This would seem to suggest an increase in cultivation in Canada and also a shift in police priorities to cultivation offences.

CONCLUSIONS

Conclusions of Chapter 14	
	➢ **Annual costs for drug enforcement in Canada can be estimated at between $700 million and $1 billion.** ➢ **Reduced law enforcement activities resulting from amendments to the drug legislation on cannabis could produce either substantial savings or significant reallocations of funds by police forces to other priorities.** ➢ **Due to the consensual nature of drug offences, police have been granted substantial enforcement powers and have adopted highly intrusive investigative techniques; these powers are not unlimited, however, and are subject to review by Canadian courts.** ➢ **Over 90,000 drug-related incidents are reported annually by police; more than three-quarters of these incidents relate to cannabis and over 50% of all drug-**

[79] *Ibid.*

related incidents involve possession of cannabis.

- **From 1991 to 2001, the percentage change in rate per 100,000 people for cannabis-related offences is +91.5– thus, the rate of reported cannabis-related offences has almost doubled in the last decade.**
- **Reported incidents related to the cultivation of cannabis have seen a dramatic increase in the last decade.**
- **Reported incident rates vary widely from province to province.**
- **Cannabis was involved in 70% of the approximately 50,000 charges in 1999. In 43% of cases (21,381), the charge was for possession of cannabis.**
- **Charge rates for drug offences vary significantly from province to province.**
- **The uneven application of the law is of great concern and may lead to discriminatory enforcement, alienation of certain groups within society, and creation of an atmosphere of disrespect for the law; in general, it raises the issue of fairness and justice.**
- **Seizure statistics would seem to confirm an increase in cannabis cultivation in Canada and also a shift in police priorities regarding this offence.**

CHAPTER 15

THE CRIMINAL JUSTICE SYSTEM

The previous chapter examined how people first come into contact with the criminal justice system through the enforcement of criminal legislation. Several questions remain, however. What happens once a person has been charged with a drug offence? Who is responsible for prosecuting drug cases? What type of punishment do people receive? Who ends up with a criminal record? Have there been any challenges to the constitutional validity of drug legislation? These issues and others related to the criminal justice system are reviewed in this chapter.

PROSECUTION

The Federal Prosecution Service (FPS) is the lead prosecution agency with respect to drug offences in Canada. Its mandate is to prosecute offences in every province and territory under a variety of federal statutes, including the CDSA. Its work consists mostly of drug prosecutions.

Under the CDSA, provinces can exercise jurisdiction to prosecute if a drug proceeding was commenced at the instance of the provincial government. Presently, only two provinces–Quebec, and to a lesser extent New Brunswick–have exercised this jurisdiction. Thus, in Quebec, the FPS prosecutes only offences that have been investigated by the RCMP. In the rest of Canada – apart from New Brunswick – the service prosecutes drug offences that have been investigated by a provincial or municipal police force or the RCMP.

The FPS has 300 full-time in-house lawyers in 13 offices across the country and approximately 750 standing agents from the private sector, who conduct drug prosecutions on behalf of the Attorney General of Canada. Generally, the police investigate an offence and lay a charge, which is followed by a prosecution. In certain provinces – such as British Columbia, Quebec and New Brunswick–the police are required to seek Crown approval before laying a charge.

While complex cases still represent a fairly small percentage of cases prosecuted by the FPS, they are becoming more common and are already very time consuming for prosecutors.

> *...Most cases are of low or medium complexity; however, the complexity of cases is increasing and complex cases are becoming more common. Currently, it is estimated that complex cases make up 7 percent of the caseload but use 60 percent of prosecutors' time. Complex organized crime cases require the involvement of Justice at an early stage because of the legal issues associated with the collection, organization, and admissibility of evidence.* [1]

The total cost of drug-related prosecutions conducted by the FPS is approximately $57 million per year–$35 million for in-house counsels and $22 million for standing agents. The FPS estimates that for the year 2000-2001, the cost of prosecuting cannabis possession was approximately $5 million, or roughly 10% of the total budget of $57 million.[2]

COURTS

During our deliberations, we were not given much detail on the costs to the provincial court system of drug-related prosecutions. The 1996 study by CCSA already presented in a previous chapter[3] estimated court costs for 1992 at approximately $60 million. One would assume that, with nearly 50,000 people currently charged per year for drug offences, and with the increased complexity of these cases, court administration costs would be significantly higher than the amount estimated in 1992.

The Auditor General estimated that in 1999 Canadian criminal courts heard 34,000 drug cases that involved more than 400,000 court appearances.[4] Other court-related costs are the considerable resources spent on legal aid. While we did not receive information on how much of these costs should be allocated to drug-related offences, we do know that in 1996/1997, $860 million was spent on court administration costs, and that in 1997/1998, $455 million was spent on legal aid.[5]

Drug treatment courts

Drug courts originated in the USA in the late 1980s as one of the measures in the "war on drugs". The arrangement essentially involves permitting the judge hearing a

---

[1] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 12.

[2] Croft Michaelson, Director and Senior General Counsel, Strategic Prosecution Policy Section, Department of Justice, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 22, page 54.

[3] Single, E. et. al., (1996) *op. cit.*

[4] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 4.

[5] Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Justice Spending in Canada, Catalogue no. 85-002-XIE Vol. 19, no. 12, pages 7-9.

case involving narcotics to order treatment measures instead of any other form of sentence. There are now approximately 2,000 drug courts in the USA and they have apparently dealt with about 200,000 individuals. The primary task of these courts is to deal with offenders whose offences did not involve violence and who have a history of drug use (including alcohol). Two approaches are taken: one is applied before sentencing and the other after sentencing. In the former case, the charges are suspended and in the latter case it is the sentence of probation or imprisonment that is suspended. Responses include intensive judicial supervision, long-term clinical treatment, frequent random urine tests, and related services (housing, employment, etc.). Various assessments of the system claim that the benefits include a reduction in drug use and delinquency as well as a reduction in the costs to the criminal justice system (it costs approximately US $2,000 to deal with a delinquent in the drug court system as compared with between US $20,000 and $50,000 for a criminal conviction combined with a prison sentence).[6]

Drug courts have also been established in Australia (1999), Ireland (1998) and England (1998).

The Committee visited Canada's first drug treatment court (DTC) during its travels to Toronto. Established in 1998 as a pilot project with funding support from the National Strategy on Community Safety and Crime Prevention, this initiative brought together many players including Justice Canada, Solicitor General Canada, FPS, the Ontario government, the provincial court, the Centre for Addiction and Mental Health (CAMH), the Toronto Police Service, the City of Toronto Public Health Department and a range of community-based service organizations. The pilot project is currently funded to December 2004.

A second drug treatment court pilot project was established in Vancouver in December 2001. It also uses an inter-sectoral model and is intended to ensure intensive case management and linking of participants to community resources and skills development programs, as required. While the Toronto DTC uses the Centre for Addiction and Mental Health as its treatment provider, treatment providers in Vancouver tend to be more locally based.

Drug treatment courts are specifically designed to supervise cases of drug-dependent offenders and are based on knowledge that incarceration alone does not lead to a reduction in drug use and related criminal activity. Typically, the criminal justice system does not address substance abuse problems or the root causes of these problems – which may include unemployment, homelessness, physical and sexual child abuse histories, family discord and a range of mental and physical health problems. DTCs are based on research that demonstrates that offenders with substance abuse problems commit fewer crimes when they are enrolled in treatment programs.

---

[6] See, *inter alia*, the document prepared by the Canadian Centre on Substance Abuse (2000) *Drug treatment courts: Substance abuse intervention within the justice system.* Ottawa: author.

Another underlying assumption is that through therapeutic jurisprudence approaches such as drug courts, which are intended to provide rehabilitative and reintegration outcomes for drug-addicted offenders, the criminal justice system, in partnership with treatment providers and community services, can act as a change agent in altering the course of the addict's life.[7]

The Toronto DTC provides court-supervised treatment for people who have a dependency on cocaine and/or opiates. Non-violent drug-dependent offenders charged with possession of, or trafficking in, small amounts of crack/cocaine or heroin, or with prostitution-related offences, are eligible for the program. In all cases, the offender is screened and assessed by a treatment provider. Admission is voluntary but must be approved by the Crown. Factors considered include other current criminal charges, the potential for risk to the community and the seriousness and circumstances of the offence. Two tracks have been established. In general, the first track is for those with limited or no criminal record and a charge of simple possession. They are eligible to enter the DTC prior to plea–once the program is completed, the charge is stayed or withdrawn. The second track is for those with more serious criminal records or a trafficking charge. They are required to plead guilty–once phase I of the program is completed, the offender receives a non-custodial sentence and is placed on probation (phase II). Failure to complete phase I results in the offender being expelled and sentenced.

The system is based on close collaboration between the Court and treatment systems. The offenders attend court sessions on a regular basis–the court sits twice a week–where the judge, in consultation with the DTC treatment team, reviews their progress. The DTC team includes the DTC judge, crown prosecutor, duty counsel, a representative of probation services, court staff, community/court liaison staff and treatment staff. Decisions are made regarding future treatment and judicial involvement. Continued compliance is encouraged through a system of graduated incentives and sanctions–this is accomplished by releasing the offender on bail with appropriate conditions that must be satisfied. Relapses are anticipated as part of the recovery process and do not automatically lead to expulsion. Honesty and accountability are important, however. Failure to meet other conditions, such as attendance in court or providing a urine sample, can result in a range of sanctions, including revocation of bail for up to five days.

The offender is involved in a structured outpatient program geared to his or her specific needs. Treatment lasts approximately one year, during which the offender works closely with a case manager. Treatment includes: group and individual counselling, ongoing case management, regular and random drug screening, and addiction medicine services – including methadone maintenance where appropriate. Treatment staff also collaborate closely with community resources and agencies to meet

[7] Patricia Begin, Director, Research and Evaluation, National Crime Prevention Centre, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 22, page 57.

the needs of participants. To complete the program, the offender must not have used crack/cocaine and/or heroin for an extended period of time and must also demonstrate a fundamental life-style change involving improved interpersonal skill development, stable and appropriate housing, and educational and vocational success.

The DTC initiative seems very encouraging although it is clear that evaluations will have to be conducted to ensure that these programs are effective. We were told that there are very few existing comprehensive, well-designed evaluations of drug treatment courts but that results of more comprehensive evaluation should be ready in 2002-2003. Problems to date include the following: most of the evaluations or research have taken place within very limited time frames; there has been no significant follow up to look at whether there has been re-use or abuse of drugs and criminal recidivism; and there has been a lack of adequate comparison groups from which to draw conclusions about the impact and effects of the program. Also discussed were differences from American drug courts, where mandatory minimum sentences and harsher penalties in general are a significant incentive for American participants to remain with the program.[8] Patricia Begin, Director of Research and Evaluation at the National Crime Prevention Centre, provided the following preliminary details of the Toronto DTC:

> *Briefly, the Toronto evaluation is using a quasi-experimental design. The comparison group is composed of those clients who were assessed as eligible to enter the program and made the decision not to participate in the drug treatment court, but rather go through the traditional criminal justice processing.*
>
> *Between April 1999, when the evaluation data started to be collected, and October 5, 2001, there were 284 clients involved in the drug treatment court. Eighty-three per cent, or 234, are the experimental group, and 17 per cent constitute the comparison group of 50 clients.*
>
> *In the experimental group, 16.7 per cent are still in the program; 13.7 or 14 per cent have graduated, which is 32 graduates; and 62 per cent have been expelled. The overall retention is 31 per cent.*
>
> *One of the things the research has illuminated is that for those drug treatment court clients who make it past the three-month period, the retention rate rises to 50 per cent. The court is attempting, through the data, to better understand the characteristics of those clients who are deemed to be eligible but do not make it, and who are expelled or withdraw in the first three months.*
>
> *...The evaluation has found that the comparison group is more likely than the experimental group to be younger, unemployed, have an income source from illegal activity, more criminal convictions, have been incarcerated more often and been charged with a new offence since admission to the drug treatment court. In many respects, the comparison group is at much higher risk than the experimental group.*
> *Lower reoffending rates for those receiving the drug treatment court program and related services may be related to their level of risk. We would like to explore further whether it is participation in the program, or lower risk and motivation to change one's life that is accounting for these differences.*

---

[8] *Ibid.*, page 8.

> *The evaluation data that we have to date has told us the following: The drug treatment court in Toronto is able to engage and retain offenders. Those who stay in the program tend to complete it and graduate, and the limited follow-up data that has been collected so far would indicate that they do have lower recidivism rates and reduced drug use.*
>
> *There is also a reduction in drug use and criminal activity while offenders are in the program. There tend to be lower re-arrest rates for the experimental group compared with the expelled or the comparison group. One of the evaluation challenges over the next couple of years will be to try to identify a better matched group of offenders in order to define the outcomes, impacts and effects of the drug treatment court experience on some of the key outcome measures, which have to do with drug use, criminal activity, re-insertion in a pro-social way into the community, family stability and things of that nature.*[9]

We look forward to the results of more comprehensive evaluations. Of note, the cost of incarceration in Ontario is approximately $45,000 per year while treatment costs related to drug courts are estimated at $4,500 per year. Clearly, increased use of DTCs could lead to substantial savings to the criminal justice system while at the same time showing promising results in reducing substance abuse problems.

DISPOSITION AND SENTENCING

While the quality of criminal justice statistics has been discussed in other chapters, the weakness in these numbers is particularly evident with respect to the disposition and sentencing of drug-related offences. This issue was also raised in the Auditor General's report for 2001.

> *There are weaknesses in some aspects of law enforcement statistics. First, there are no national statistics on illicit drug convictions and sentencing. For example, British Columbia, Manitoba, New Brunswick, and Nunavut do not provide adult criminal court data to Statistics Canada. The use of statistics requires good analysis and interpretation to understand underlying trends and causes. Because Canada does not have national data, it cannot monitor important trends such as sentence lengths, emergence of new drugs, and regional differences…*
>
> *A second weakness is that the statistics on drug convictions and sentencing, which are reported according to the categories under the Controlled Drugs and Substances Act, are limited in detail. While the national statistics on police charges break down the number of drug charges by both type of substance (for example, heroin, cocaine, and cannabis) and act (for example, possession, trafficking, importation, and cultivation), the statistics on convictions are broken down into only two categories - possession and trafficking. The Inter-American Drug Abuse Control Commission's 1999-2000 report on Canada's*

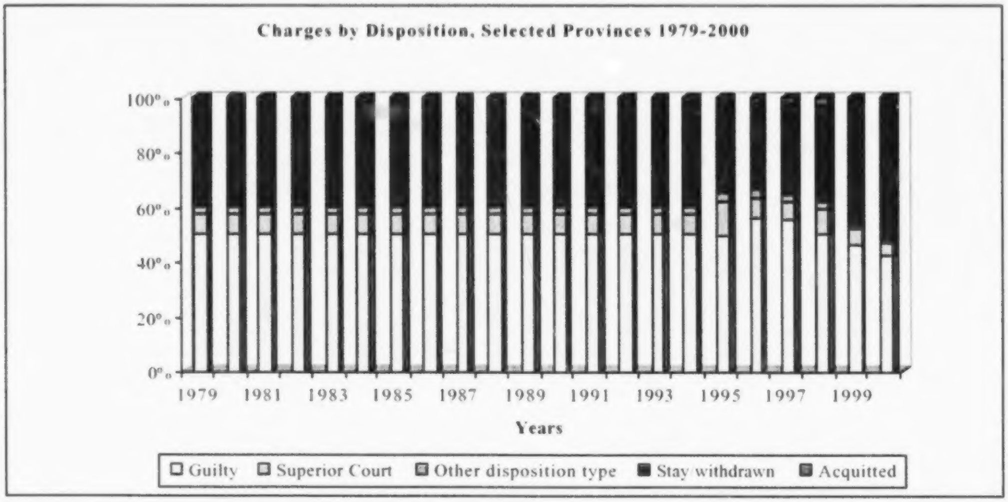
---

[9] *Ibid.*, pages58-60.

progress in drug control stated that improvements were needed in the justice system's statistics on drug offences. [10]

Despite these weaknesses, data relating to the disposition and sentencing of drug-related offences will be reviewed.

The following figure details the outcome of those charged with drug offences in selected provinces. It would appear that, from 1995 to 2000, there was a fairly significant increase in the percentage of cases in which the charges against the accused were either stayed or withdrawn. Not surprisingly, the percentage of people being found guilty of drug offences once they had been charged was lower. It is important to note, however, that this figure does not include data from three of the provinces (New Brunswick, Manitoba and British Columbia) and from one of the Territories (Nunavut); nor does it include data from certain courts in Quebec. Also, the data prior to 1995 are based on approximations of the average distribution of charges during the period covering the years 1995 to 2000.



For the year 1996-1997, 64% of persons convicted of drug trafficking were sentenced to imprisonment. The median sentence was four months. Probation was imposed as the most serious sentence in 24% of these cases and fines, in 9%.[11]

---

[10] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 15.

[11] Statistic Canada, Canadian Centre for Justice Statistics, *Juristat*, Illicit Drugs and Crime in Canada, February 1999, page 7.

With respect to possession, a fine was imposed in 63% of the cases, with a median amount of $200. A fine was imposed as the most serious sentence in 55% of cases, probation in 22% and imprisonment in 13%.[12]

We were informed that the FPS is attempting to identify and implement alternatives to prosecution where appropriate. For example, "diversion" – whereby first-time offenders who have been charged with simple possession of cannabis are diverted out of the formal criminal justice system – was mentioned. Also discussed were the drug treatment court pilot projects in Toronto and Vancouver, whereby addicted offenders are referred to a fairly rigorous court-monitored treatment program. In addition, we were told about the recent implementation of the "deferred prosecution pilot project," in which prosecutors post a peace bond for offenders who have been charged with possession of cannabis in Manitoba. In these cases, the charges would be stayed, and as long as the offender is not back before the court system within a period of one year, the matter would be discontinued. Other "diversion" programs across Canada were mentioned.[13]

While Canada's disposition and sentencing data are incomplete, a few studies of limited scope suggest what is happening in Canada. A document prepared by the *Comité permanent de lutte à la toxicomanie* reviews police and judicial practices based on Quebec statistics from 1985 to 1998.[14] The report found that practices varied from one region to another in Canada and also from one region to another in Quebec. It notes that while there is a trend towards greater use of diversion in cannabis possession cases, it is far from being a standard practice. Diversion was used more often in the case of minors and, in their case, is on the rise (20.6 % in 1990, 48.2 % in 1995, 55.9 % in 1996 and 63 % in 1997). Once again, this varies considerably from one region to another.

Of those charged with cannabis possession, approximately 80% were adults and mostly male (roughly 90%). The report noted that penalties were not severe, particularly where it involved only one offence. For adults, the majority of the penalties imposed by the courts were fines and probation, and very rarely imprisonment. For minors, the most common penalty was community work or probation; detention was rarely imposed. Data from Montreal in 1998 indicate that incarceration for cannabis possession was less likely (13.8 % of all sentences) than for other substances, and that such penalties were shorter (50% were for 1 day and none was for more than 10 days). In addition, fines were smaller (average fines for cannabis were $186 while they were $277 for cocaine).

---

[12] *Ibid.*

[13] Croft Michaelson, Director and Senior General Counsel, Strategic Prosecution Policy Section, Department of Justice, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 22, pages 54-55.

[14] Comité permanent de lutte à la toxicomanie, *La déjudiciarisation de la possession simple de cannabis*, June 1999, pages 11-13.

Patricia Erickson, a researcher from the Centre for Addiction and Mental Health, provided information on cannabis criminals based on three studies conducted in Toronto in 1974, 1981, and 1998. The studies indicate that cannabis criminals were overwhelmingly young men (about 90% were male and more than half were aged 21 years or less). Of the sample group, 80% were employed or in school and about half lived with parents. Most offenders were charged with only one count of simple possession and the amounts involved were small. In over 75% of the cases, charges were based on possession of less than 14 grams of cannabis. Of the whole sample interviewed in 1998, 50% had 1 gram or less of cannabis as the basis for their cannabis possession charges.

With respect to sentencing, in the first two studies, an absolute or conditional discharge was ordered in a large proportion of the cases. In 1998, 43% were diverted and the rest were awaiting disposition. It was indicated that penalties seemed to be given out randomly and that there "*was no correlation between sentence received and the type of person they were, or the case characteristics, charge and amount of drug.*"[15]

Also discussed was the issue of deterrence. The first study noted that 92% were still users one year later (in the later studies, about 80% intended to use cannabis or were still using it). In addition, the studies noted that the severity of the penalty was not relevant in deciding whether to use it in the future. The factor that best predicted an end to use after the user was arrested was simply the quantity the offender had used in the past–the less used the more likely the user was to stop. There was also no evidence of general deterrence, although it was indicated that this is much more difficult to measure.

While diversion programs are certainly an improvement on the traditional justice system response, it would seem that these programs are being developed on an ad hoc basis and are not consistently available across the country. Thus, while some offenders may benefit, others are left to face the traditional criminal justice system. In addition, it is not clear whether the admission criteria are similar under the various diversion initiatives. This would suggest an uneven application of the criminal law with respect to offenders who have committed the same offence, with the disposition of a case based not on the offence itself but rather on where it was committed.

CORRECTIONS

[15] Dr. Patricia Erickson, Researcher, Centre for Addiction and Mental Health, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 2, page 90.

Correctional Service Canada (CSC) is responsible for offenders serving sentences over two years, including individuals convicted of serious drug offences. CSC estimates that:

- nearly 70% of federal offenders have problems with alcohol and/or drugs;
- more than half used drugs or alcohol when they committed their current offence; and
- approximately 20% of incarcerated offenders have been convicted of drug-related offences.

With such numbers, it is obvious that substance abuse should be a high priority for CSC. This raises two issues: (1) how to address the supply of drugs in federal institutions; and (2) how best to provide treatment and rehabilitation for offenders with substance abuse problems.

With respect to security measures, CSC conducts searches, does urinalyses and works with police to share intelligence about drug issues. In addition, ion scanners have recently been set up in every institution to help detect the introduction of drugs. There are also plans to have a drug detection dog in every institution. Despite all these security measures, it would be difficult for CSC to argue that it is successfully keeping psychoactive substances out of prisons. The national results from a random urinalysis sample program in 2000-2001 found that 12% of samples tested positive for at least one intoxicant.[16] In addition, a recent study in Quebec penitentiaries shows that 29% of inmates admit to illicit drug use, the majority of them taking cannabis.

> *Imprisonment does not necessarily address the problem. A study that we conducted recently in Canadian penitentiaries in Quebec showed that inmates are taking drugs there too. We asked inmates to tell us about their drug use habits over the past three months of imprisonment. All the inmates were men. Sixteen per cent of them told us that they had consumed alcohol, whereas 29 per cent said that they had taken illicit drugs. In the majority of cases, these inmates were taking cannabis, whereas on the outside, the same inmates used to take cocaine. This is a significant change. Why were these people consuming cannabis, which is more readily detectable by its smell and by the traces it leaves in urine? Cannabis is detectable for 15 days after it was consumed, whereas cocaine can only be detected for 48 hours afterwards. Inmates want to escape. Cocaine is a stimulant which brings the inmate back to reality and this is not the desired effect. These people want to escape. Tranquillizing substances are the favourite. Sometimes they take benzodiazepine. However, they are easily able to get their hands on cannabis.*[17]

CSC provides substance abuse and treatment programs to offenders with drug problems. A range of programs is available to help offenders break the cycle of

[16] Paul E. Kennedy, Senior Assistant Deputy Solicitor General, Policing and Security Branch, Department of the Solicitor General, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 22, page 10.

[17] Serge Brochu, Professor, University of Montréal, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 12, pages 23-24.

addiction and safely reintegrate back into the community. Programs include the Offender Substance Abuse Prevention Program, the CHOICES Program and the Substance Abuse Program for Long-Term Offenders. CSC has also introduced Intensive Support Units, which include added searching and testing to support offender efforts to change substance abuse behaviour. The Auditor General estimates that 53% of offenders participate in substance abuse programs while serving their sentences.[18]

With respect to harm reduction, CSC provides methadone treatment to some opiate-addicted injection drug users and also makes bleach available in prisons to sterilize needles. CSC also has other initiatives to prevent the spread of infectious diseases, such as immunization for Hepatitis B. In early 2002, CSC announced an expanded methadone treatment program for federal prisoners addicted to heroin and other opiates.

CSC's Addictions Research Centre (ARC) opened in Montague, Prince Edward Island, in May 2001. The mandate of the ARC is to conduct applied research to assist the CSC in understanding issues surrounding substance abuse and to develop programs that assist offenders in breaking their drug dependency. It is the only research centre established by a correctional organization to specifically address the challenges of addictions. With a staff of 20, it currently focuses on four areas: program development – which is currently focused on culturally sensitive programs for women and Aboriginal offenders; program research – in areas such as community intervention, methadone maintenance, intensive support units and fetal alcohol syndrome; assessment and monitoring – to measure trends over time to evaluate the success of interventions; and knowledge dissemination.

Obviously, CSC's largest cost is related to incarceration. The Auditor General estimated that in 1999, CSC spent $169 million to deal with illicit drugs: $154 million to deal with offenders serving sentences in whole or in part for drug-related offences; $8 million on substance abuse programs (including alcohol); $4 million for treatment programs (e.g., methadone); $3 million on urinalysis testing. The cost of other security measures to control supply in institutions were unknown.[19] Of the current population of approximately 13,000 federal inmates, roughly 7,000 participate in substance abuse programs while serving their sentences. About $1,150 is spent per participating offender on substance abuse programs.

As of 31 December 2000, 5,779 convicted drug offenders were under federal jurisdiction (either serving their sentence: (1) in a federal institution or (2) on conditional release). Of these, 3,890 were serving sentences for trafficking, 621 for

---

[18] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 13.

[19] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 16.

importation, 225 for cultivation and 2,221 for possession.[20] Inmates serving in federal institutions are those who have been sentenced to imprisonment for two years or more.

Of those same 5,779 convicted drug offenders serving their sentences as of 31 December 2000, 2,548 were in federal correctional institutions: 1,613 for trafficking, 113 for importation, 82 for cultivation and 1,318 for possession.[21] In addition, 3,231 were on conditional release: 2,312 for trafficking, 508 for importation, 145 for cultivation and 946 for possession.[22]

In the five-year period from 1995 to 2000, the total federal drug offender population increased by almost 9%. Most of the growth involved those on conditional release, as this population increased by 19% over this period. At the same time, the number of those serving their sentence in institutions decreased by 2%.[23]

At the end of 2000, the average time served by drug offenders in federal custody was 2.2 years. With respect to conditional release, the average time served was 3.7 years. While this figure is lower than the average for non-drug offences, it is interesting to note that the average time served in custody for possession offences was 2.52 years, while it was 1.89 years for trafficking, 1.48 years for importation and 0.88 years for cultivation. For those on conditional release, the average time served for importation was 4.6 years, while it was 3.6 years for possession, 3.5 years for trafficking and 2.2 years for cultivation.[24] CSC indicated the reason that offenders appeared to be serving longer sentences for possession offences than for other drug-related offences such as trafficking is that they may also be serving time for other more serious offences, a situation making comparisons extremely difficult.

The following figure provides details of the number of admissions by region in federal correctional institutions in relation to drug offences for the year 2000, and the number of inmates incarcerated in different regions of the country as of 31 December 2000.

---

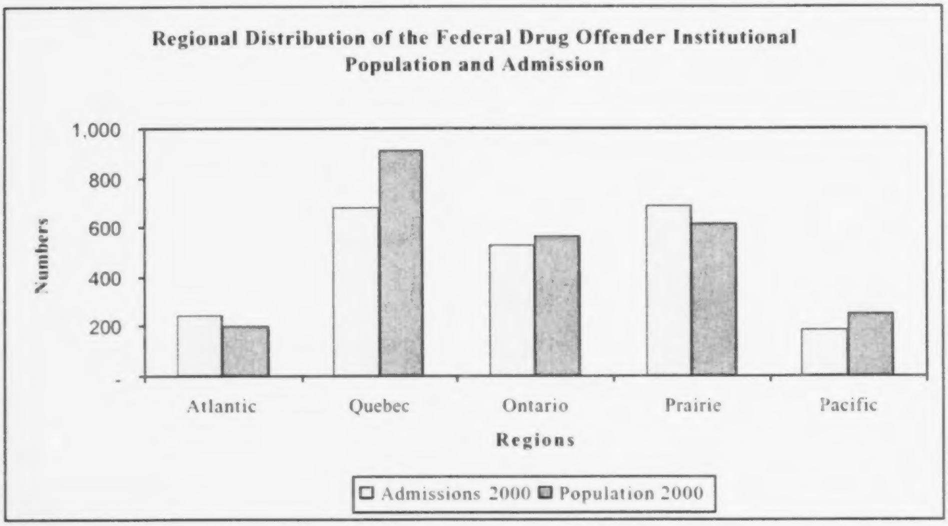
[20] Correctional Service Canada, Forum on Corrections Research, Volume 13, no. 3, September 2001, page 25. Please note that possession for the purpose of trafficking is included in the trafficking numbers.

[21] *Ibid.* It should be noted that some offenders might be represented in more than one drug offence category.

[22] *Ibid.* It should be noted that some offenders might be represented in more than one drug offence category.

[23] *Ibid.*

[24] Correctional Service Canada, *Forum on Corrections Research*, Profiling the drug offender populations in Canadian federal corrections, September 2001, Volume 13, Number 3, page 26.



CRIMINAL RECORD

So what are the consequences of a criminal conviction? There are pre-disposition costs related to the criminal justice system such as legal fees, time off from work, etc. Often, the liberty of the offender is compromised by virtue of having to go to the police station. There are also the emotional costs of worrying about having been charged with a criminal offence. Even if the charge is later withdrawn, offenders have experienced costs.[25]

Sanctions imposed in court are another obvious cost to the offender. They could include probation, a fine or some other sentence. Finally, there are also post-conviction costs. For example, a criminal conviction can have a negative impact on a person's employment opportunities and can be an impediment to travel to other countries. The general stigma of criminalization affects all offenders. Those offenders receiving harsher sentences generally feel unfairly treated, a feeling that can lead to a lack of respect for the administration of justice.[26]

---

[25] Dr. Patricia Erickson, Researcher, Centre for Addiction and Mental Health, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 2, pages 82-90.
[26] *Ibid.*.

Allan Young made the following statement

> *I get two to three calls a week from otherwise law-abiding citizens who are pot smokers who have been fired from their jobs or have been denied entry into the United States or access to their children or government employment. These people have been treated like common criminals. This is the biggest problem with the marijuana prohibition: If you treat someone who is otherwise law-abiding as a common criminal, they will start to disrespect people like Chief Fantino and the other people who really do try to serve and protect our interests.* [27]

With respect to the costs of cannabis prohibition, Dr. Patricia Erickson indicated that we do have choices.

> *It is evident in U.S. drug policy that, the people for whom drug use is a moral issue, the cost is unimportant. The costs are irrelevant to them. What is relevant is making sure that the use of drugs is seen as wrong. In Canada, however, we have always been more balanced and more evidence-based. That is a good distinction from the U.S. Canadians are at least able to measure and discuss the costs of policy and consider alternatives. We are not willing to pay any price.* [28]

A criminal conviction can also be an important factor in future dealings with the criminal justice system. For example, a person's prior conviction: may influence a police officer to lay a charge in cases where he or she might otherwise have used their discretion not to lay a charge; may influence a crown prosecutor to proceed by indictment rather than by summary conviction; may be used in limited circumstances in subsequent criminal proceedings; and may lead a judge to impose a more severe sentence. These are not trivial matters for those who have been convicted of a drug-related offence–in particular, the offence of possession of cannabis.

What happens in the case of a conditional or an absolute discharge? Section 730 of the *Criminal Code* indicates that such a person is deemed not to have been convicted of the offence. However, such a person would in likelihood have to answer yes if he or she were asked whether they had ever been arrested for, found guilty of, or pleaded guilty to a criminal offence.

A conviction does not necessarily mean that a person has a "criminal record," that is, a record in the Canadian Police Information Centre (CPIC) System. This computerized information system for law enforcement use provides information on crimes and criminals. The Identification Data Bank–one of four CPIC data banks–contains the Criminal Record Synopsis File in which records are entered based on information contained on criminal fingerprint forms. This file contains tombstone data respecting the file–such as status of the record, subject description, subject history

[27] Alan Young, Associate Professor, Osgoode Hall Law School, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 5, page 27.
[28] Dr. Patricia Erickson, Researcher, Centre for Addiction and Mental Health, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 2, page 99.

(record, offence type) and subject aliases – and the complete Criminal Record is available to all CPIC terminal agencies upon request.

In the case of adult offenders, the Criminal Record file will be destroyed the earlier of either three years after their death and the date the individual reaches 80 years of age (although this will not apply in certain circumstances, such as where the individual has been charged with an offence within the previous 10 years). Absolute and conditional discharges will be removed to an archive as follows: absolute discharge on or after 24 July 1992 upon the expiration of one year from the date of sentencing (it is archived for five years and then destroyed); and conditional discharge on or after 24 July 1992 upon the expiration of three years from the date of sentencing (it is archived for five years and then destroyed). Discharges prior to 24 July 1992 will be destroyed on written request. Where a pardon is granted, the information about this offence is removed from CPIC to secured storage, separate and apart from all other criminal records (it is destroyed following the guidelines set out above for regular criminal record files). In the case of a charge not resulting in a conviction, the accused may make a request to the police agency that handled the case to have the information removed from local police files and RCMP records. The RCMP will return a person's fingerprints and remove the offence information from CPIC, only on the request of the police agency that handled the case. Special rules apply to young offenders.

As explained previously, even though a person does not have a "criminal record," it does not mean that the person has not been convicted of a criminal offence. While the presence of a criminal record is more likely to lead to negative consequences for the individual, many of the issues raised above also apply to those who have been convicted of a criminal offence but who do not have a "criminal record." Depending on the circumstances and on the way the question is formulated, the lack of a criminal record is irrelevant.

Because the offence of possession of less than 30 grams of marijuana is currently a summary conviction offence, a person should not be fingerprinted following arrest. Because fingerprints are the basis for a "criminal record," no such record will be entered in CPIC based only on this offence. However, before 1996, people had a criminal record, and it has been indicated that by the early 1990s, over 500,000 Canadians had a criminal record for cannabis possession.[29]

Because of the complexity of this issue, one wonders whether people who have been convicted of an offence, notwithstanding the sentence imposed or whether they have received a pardon, know their legal rights. For example, most people would probably have difficulty answering certain criminal-related questions found on employment application forms.

[29] Patricia Erickson and Benedikt Fisher, Canadian Cannabis Policy: The Impact of Criminalization, the Current Reality and Future Police Option, paper presented an the International Symposium on Cannabis Policy, Criminal Law and Human Rights, Bremen, Germany, October 5-7, 1995.

COURT CHALLENGES [30]

Not surprisingly, the cases that have challenged the substantive validity of drug prohibition laws under the Charter have so far specifically dealt with marijuana, rather than with harder drugs, such as cocaine and heroin. Cases dealing with the right to use cannabis for medical purposes have been discussed in Chapter 13. This section will review cases where a right to non-therapeutic (or recreational) drug use is claimed. Although the medical cases have met with greater success, Charter challenges to marijuana prohibition by recreational users have been taken more seriously by the courts than they were a few years ago.

So far, Canada's legislative prohibition on marijuana – as it relates to non-therapeutic use – has been consistently upheld by the courts. However, the court's reasons have become more elaborate and more extensive in recent cases than in earlier cases. Undoubtedly, this reflects, at least in part, a change in judicial perceptions of the scope of section 7 of the Charter.

No cases could be found which dealt with challenges to the ban on marijuana or other drugs under the *Canadian Bill of Rights*. Undoubtedly, this can at least in part be explained by the courts' approach to the Bill of Rights generally, and to the "due process" clause specifically. The courts took a rather cautious approach to applying the Bill of Rights which, being an ordinary statute, was not taken to "reflect a clear constitutional mandate to make judicial decisions having the effect of limiting or qualifying the traditional sovereignty of Parliament."[31] Moreover, the prevailing view of the "due process of law" standard was that it was restricted to procedural fairness, and the "liberty" interest was undoubtedly assumed to refer only to freedom from physical restraint.

The earliest case concerning a Charter challenge to the offence of possession of an illegal narcotic–in this case, marijuana–was the Quebec Superior Court judgement in *R. v. Lepage* (8 May 1989, unreported).[32] However, this case was unreported and a copy of the decision could not be found, so the reasons for the decision, including the provisions of the Charter under which the decision was made, are not available.

The British Columbia Supreme Court decision of *R. v. Cholette* (1993)[33] was the first case located that dealt squarely with a section 7 challenge to the ban on the use of marijuana. In this case, the accused claimed that the ban violated his right to security of the person under section 7. The accused cited the benefits which he derived from using marijuana and questioned the motivation of the government's original decision to ban

[30] This section relies to a great extent on *Drug Prohibition and the Constitution*, a paper prepared for the Special Senate Committee on Illegal Drugs by David Goetz, Law and Government Division, Parliamentary Research Branch, Library of Parliament, 1 March 2001.

[31] R. v. *Therens*, [1985] 1 S.C.R. 613, at page 639, per Le Dain J.

[32] Bruce A. MacFarlane, Robert J. Frater and Chantal Proulx, *Drug Offences in Canada*, Aurora, Ont.: Canada Law Book, 1996 (rev. November 2000) (loose-leaf), pages 4-27.

[33] [1993] B.C.J. No. 2616.

marijuana in 1923 (on the basis that it reflected anti-Asian bias and stereotyping), and its continued retention of the ban, on the grounds that there is no evidence of any significant harmful effect to society. Justice Dorgan rejected the accused's argument and concluded that the accused had failed to demonstrate that the ban on marijuana "interferes in any real way with the right of access to medical treatment for a condition representing a danger to the life or health of the accused…"[34]

Four months after the *Cholette* case, similar arguments were being weighed by the Quebec Court of Appeal in R. *v. Hamon* (1993).[35] This time, the accused relied on the broader conception of the liberty interest advanced by Wilson J. in *Morgentaler* arguing that the decision to use marijuana was a fundamental personal decision. He further claimed that, as marijuana is not really harmful to society – or, at least, no more harmful than tobacco or alcohol – the ban is arbitrary and irrational, and thus contrary to the principles of fundamental justice. Justice Beauregard, for the court, was prepared to assume that an arbitrary criminal prohibition would be contrary to the principles of fundamental justice.[36] However, the Court concluded that the ban was not arbitrary and accepted the expert evidence adduced by the government to the effect that cannabis use did have harmful effects on individual users and society.[37] Moreover, the court rejected the suggestion that there was anything unjust in the government's decision to treat cannabis differently from tobacco or alcohol.[38] Leave to appeal this decision to the Supreme Court of Canada was refused.

In the 1997 case of R. *v. Hunter*,[39] Justice Drake of the British Columbia Supreme Court addressed a challenge to the prohibitions on marijuana and psilocybin under various Charter provisions. With respect to the accused's arguments that the prohibitions violated his section 7 liberty and security of the person interests, Justice Drake summarily dismissed them, stating simply that *"the two statutes contain reasonable prohibitions against certain conduct, and these are not unduly broad in their application"* and referring with approval to the Quebec Court of Appeal decision in *Hamon*.[40]

In the preceding cases involving challenges to the ban on marijuana (and psilocybin, in the case of *Hunter*) under section 7 of the Charter, the courts dismissed the arguments with little detailed reasoning. However, in two provincial courts of appeal decisions released in 2000, similar arguments were the subject of more extensive analysis.

The first of these two cases was R. *v. Malmo-Levine* (and its companion case of *Regina v. Caine)*,[41] a decision of the British Columbia Court of Appeal released on

[34] *Ibid.*, at para. 9.
[35] 20 C.R.R. (2d) 181, [1993] A.Q. no. 1656.
[36] *Ibid.*, at p. 183 C.R.R. and para. 14, [1993] A.Q.
[37] *Ibid.*, at p. 183-84 C.R.R. and paras. 17-20, [1993] A.Q.
[38] *Ibid.*, at p. 185 C.R.R. and paras. 22-26, [1993] A.Q.
[39] [1997] B.C.J. No. 1315.
[40] *Ibid.*, at para. 15.
[41] [2000] B.C.J. No. 1095.

2 June 2000. In this case, a majority of the court upheld the criminal prohibition on simple possession of marijuana as being in conformity with section 7 of the Charter.

First, the Court decided that the accused's section 7 liberty interest was engaged by the fact that the penalty for the offence provided for possible imprisonment; and that it was therefore unnecessary to decide whether personal recreational use of marijuana was independently protected as an element of "liberty."[42]

Justice Braidwood, for the majority, then turned to the task of identifying and defining the principles of fundamental justice applicable in the case. After considering relevant common law and constitutional jurisprudence, scholarly legal and philosophical writings (in particular, those of John Stuart Mill), and law reform commission reports, the Court accepted the accused's argument that the principles of fundamental justice as set out in section 7 of the Charter include a precept referred to as the "harm principle," pursuant to which a person ought not to be imprisoned unless there is a potential that his or her activities will otherwise cause harm to others.[43] Moreover, this principle requires that the degree of harm involved "must be neither insignificant nor trivial."[44]

Recognition of the "harm principle" as a principle of fundamental justice is consistent with the assumption made by the Quebec Court of Appeal in *Hamon*, that a prohibition that was arbitrary and irrational would be contrary to section 7 of the Charter.

As in *Hamon*, the majority of the Court in *Malmo-Levine* found that the prohibition was not arbitrary. Justice Braidwood, for the majority of the Court, held that the criminal prohibition on possession of marijuana satisfied the harm principle. The majority concluded that Parliament had a "reasonable basis" to ban marijuana based on the following findings concerning the health risks associated with its use:

- Impairment of ability to drive, fly, or operate complex machinery–in this regard, users represent a risk of harm to others in society as well as to themselves (however, the number of accidents attributable to marijuana use cannot be said to be significant).
- Risk that the person will become a "chronic" user. Approximately 5% of marijuana users are chronic users; and it is impossible to tell in advance who is likely to become a chronic user. There is a risk that marijuana use, and with it the total number of chronic users, would increase if it were legalized.
- Increased health risks to "vulnerable persons" such as young adolescents.
- Risk of added costs to the health care and welfare system with increased use of marijuana (although, at current rates of use, such costs would be "negligible" compared with those associated with tobacco or alcohol use).[45]

---

[42] *Ibid.*, at para. 69.
[43] *Ibid.*, para. 134.
[44] *Ibid.*, para. 138.
[45] *Ibid.*, para. 142.

Justice Braidwood then proceeded to weigh the interests of the state versus the rights of the individual, as prescribed by the Supreme Court of Canada in *Cunningham*, to determine if the criminal prohibition on marijuana possession struck "the right balance" between the individual and society. On the side of the individual, the Court weighed the deleterious effects on the individual and his or her family of imprisonment, and of having a criminal record. The Court also noted the disrespect and distrust for the drug laws fostered by the prohibition on marijuana possession. With respect to the state interest in retaining the ban on marijuana possession, the Court weighed the fact that it serves to minimize the harm to potential users and to society associated with cannabis use which, "however small, … is neither insignificant nor trivial."[46] The Court also noted that, in practice, a person convicted of simple possession of marijuana can likely expect a minor fine or a discharge, unless the person is a repeat offender.[47] Nonetheless, the Court observed, the threat of imprisonment remains and, in any event, "every year thousands of Canadians are branded with criminal records for a 'remarkably benign activity.' "[48]

In the end, Justice Braidwood observed that the result of the balancing of interests was "quite close," and that "there is no clear winner."[49] However, he noted that Parliament is owed some deference in matters of public policy and returned to his conclusion that, although the threat posed by marijuana was not large, it did not need to be for Parliament to act.[50] The principles of fundamental justice demand only a "reasoned apprehension of harm."[51] As this had been demonstrated, the majority dismissed the accused's section 7 challenge to the prohibition on marijuana possession.

In a dissenting opinion, Justice Prowse, while agreeing with much of Justice Braidwood's analysis, found that section 7 and the harm principle required a greater degree of harm to justify a criminal prohibition than merely non-trivial or not insignificant. Because the accused was able to demonstrate the absence of evidence indicating a reasonable apprehension of "serious, substantial or significant" harm, Justice Prowse would have ruled that the criminal prohibition on simple possession violated section 7 of the Charter.[52]

The Ontario Court of Appeal decision in *R. v. Clay*,[53] released on 31 July 2000, dealt with almost the same issues and arguments as those in *Malmo-Levine*. Moreover, a unanimous panel of the Ontario Court of Appeal reached the same conclusion as the majority in the British Columbia Court of Appeal judgement released the previous month.

---

[46] *Ibid.*, at para. 150.
[47] *Ibid.*, at para. 153.
[48] *Ibid.*, at para. 155.
[49] *Ibid.*, at paras. 155 and 156.
[50] *Ibid.*, at paras. 156 and 158.
[51] *Ibid.*, at para. 158.
[52] *Ibid.*, at paras. 165 and 167-86.
[53] (2000), 49 O.R. (3d) 577.

In *Clay*, Justice Rosenberg, for the court, accepted the "harm principle" elucidated by Justice Braidwood in *Malmo-Levine.*[54] Justice Rosenberg noted, among other things, that the notion of a "harm principle" encompassed by section 7 would be consistent with Justice Sopinka's statement in *Rodriguez* that where the *"deprivation of the right in question does little or nothing to enhance the state's interest (whatever it may be), it seems … that a breach of fundamental justice will be made out, as the individual's rights will have been deprived for no valid purpose."*[55]

Moreover, in applying the "harm principle" to the criminal prohibition on marijuana possession, the Court came to the same conclusion as the majority in *Malmo-Levine*: Because there is some evidence of harm caused by marijuana use that is neither trivial nor insignificant, Parliament has a rational basis to act as it has done and the marijuana prohibition is therefore consistent with the principles of fundamental justice in section 7.[56]

Justice Rosenberg, for the Court in *Clay*, noted that while the original basis for extending the ban on narcotics to include marijuana may have involved *"racism"* as well as *"irrational, unproven and unfounded fears,"* the valid objective of protecting Canadians from harm has remained constant.[57] The Court also rejected the relevance (for the purposes of constitutional analysis) of arguments and evidence showing that other legal substances, such as alcohol and tobacco, cause greater harm than marijuana: *"[t]he fact that Parliament has been unable or unwilling to prohibit the use of other more dangerous substances does not preclude its intervention with respect to marijuana, provided Parliament had a rational basis for doing so."*[58] The Court concluded that it did and upheld the prohibition on marijuana possession, except as it related to persons who need it for medical reasons (which was dealt with by the Court in the companion case of R. *v. Parker*–discussed below).[59]

As in *Malmo-Levine*, the Court in *Clay* found that section 7 of the Charter was triggered by the possibility of imprisonment, which implicated the accused's liberty interest. However, the Court in *Clay* went further and addressed the argument that personal use of marijuana *per se* was protected as an aspect of liberty and/or security of the person based on the expanded conception of these interests recognized by Justices of the Supreme Court of Canada in decisions such as: *B. (R.) v. Children's Aid Society of Metropolitan Toronto*; *New Brunswick (Minister of Health and Community Services) v. G. (J.)*; and *Rodriguez* (all discussed above). The Court concluded that personal marijuana use (apart from its genuine medicinal use) did not engage the *"wider aspect of liberty"* which protected the freedom to make decisions of *"fundamental personal importance."*[60] Nor did it fall within the sphere of personal autonomy, which encompassed the right to "make

[54] *Ibid.*, at paras. 28-31.
[55] *Ibid.*, at para. 31.
[56] *Ibid.*, at paras. 34 and 37.
[57] *Ibid.*, at para. 34.
[58] *Ibid.*, at para. 36.
[59] *Ibid.*, at paras. 37 and 38.
[60] *Ibid.*, at para. 13.

choices concerning one's own body" and a right to "basic human dignity" as aspects of security of the person.[61]

The *Malmo-Levine, Caine* and *Clay* cases are currently before the Supreme Court of Canada. The cases will revolve around whether section 7 of the Charter contains the "harm principle" and the associated question of what is the appropriate threshold of harm: is it enough that the harm is "neither insignificant nor trivial" or must there be reasonable apprehension of serious, substantial or significant harm?

CONCLUSIONS

Conclusions of Chapter 15
➢ **The cost of prosecuting drug offences in 2000-2001 was $57 million with approximately $5 million or roughly 10% of the total budget relating to prosecuting cannabis possession offences.**
➢ **In 1999, it is estimated Canadian criminal courts heard 34,000 drug cases that involved more than 400,000 court appearances.**
➢ **The Drug Treatment Court initiatives seem very encouraging, although comprehensive evaluations are needed to ensure these programs are effective.**
➢ **Disposition and sentencing data with respect to drug-related offences are incomplete and there is an urgent need to correct this situation.**
➢ **Correctional Service Canada spends an estimated $169 million annually to address illicit drugs through incarceration, substance abuse programs, treatment programs and security measures; expenditures on substance abuse programs are unreasonably low, given the number of inmates who have substance-abuse dependence problems.**
➢ **A criminal conviction can negatively affect a person's financial situation and his or her career opportunities, and restrict travel. In addition, it can be an important factor in future dealings with the criminal justice system.**
➢ **Provincial courts of appeal have so far maintained the constitutionality of cannabis prohibition. They have found that because there is some evidence of harm caused by marijuana use that is neither trivial nor insignificant, Parliament has a rational basis to**

[61] *Ibid.*, at paras. 14-18.

	act as it has done, and the marijuana prohibition is therefore consistent with the principles of fundamental justice in section 7 of the Charter. These decisions have been appealed, and the Supreme Court of Canada will soon decide whether cannabis prohibition is constitutionally sound.

CHAPTER 16

PREVENTION

Prevention is a key component of public health strategies and is increasingly part of the array of measures used to fight crime, especially crime related to the abuse of psychoactive substances. Viewed–in theory, at least–as a public health issue, an illegal drugs policy should therefore call for a strong prevention strategy.

Nothing, however, is more fluid, vague, even controversial, than prevention. The measures used to enforce the law are clear: they give power to the police and set down guidelines for the courts in dealing with people found to be in breach of the law. Correctional measures are equally clear: they implement the sentences imposed by the courts. Already, the measures used to treat people with drug problems are vague; there is no consensus on what constitutes treatment, when treatment begins and, most importantly, when treatment ends. The literature makes a distinction between primary, secondary and tertiary prevention; prevention through social development and situational development; universal, specific and indicated prevention; and prevention of use, at-risk behaviour and abuse, yet does not agree on the specific content of each field or the approach that should be taken in public policy.

When it comes to illegal drugs, the legal and political context makes the issue of prevention even harder to clarify and actions even harder to define. There are policies and initiatives in place that aim to prevent at-risk behaviour related to alcohol, such as heavy drinking, driving under the influence and domestic violence. In some circumstances and used in some forms, alcohol can be a "dangerous" substance; what we want to do is preclude those circumstances and identify the indicators of abuse so that we can prevent at-risk behaviour from leading to excessive, even pathological behaviour. It is possible to make these distinction and not deal with use *per se* because alcohol is a legal substance. But the national legal context surrounding illegal drugs and the interpretation of international drug policies (see Chapter 19 on the latter subject) are such that because they are defined *a priori* as harmful substances, illegal drugs must not be used. Another way of putting it is that any use is abuse. The glossary published by the United Nations Office for Drug Control and Crime Prevention states:

In the context of international drug control, drug abuse constitutes the **use** *of any substance under international control for purposes other than medical and scientific.*[1] *(Our emphasis)*

If use is abuse, if individuals or organizations involved in prevention are unable to make distinctions that are essential in setting objectives and devising preventive measures, what hope is there of establishing successful prevention programs?

The international context on drugs is decidedly full of surprises. Each year, the International Narcotics Control Board, whose mandate is to monitor the implementation by Member States of the various international conventions, publishes an annual report which includes, in its first section, a commentary on a specific theme. The 1997 report commented on prevention. Regretting that the social environment was promoting drug use, the report noted:

Preventing the abuse of drugs is becoming an increasingly difficult endeavour, at least partly because of the rapid and growing spread of messages in the environment that promote drug abuse. Many of them can be regarded as public incitement and inducement to use and abuse drugs. Therefore, present efforts at prevention need to be strengthened and innovative prevention initiatives need to be developed and implemented.

(...)

While the elimination of all forms of drug experimentation, use and abuse will never be achieved, it should not be a reason to give up the ultimate aim of all prevention efforts, namely a drug-free society.[2]

Among the various factors favourable to drug use and abuse, the Board cited popular culture (songs, films, etc.), the media, the Internet, the promotion of hemp products and political campaigns. The report equates advocating for liberal policy options to the promotion of drug use and suggests a rather disquieting notion of prevention:

Sensationalism, the desire to be provocative and the need for higher ratings, may also be behind the fact that several television companies in some countries in western Europe appear to be broadcasting many more programmes in support of a change in the drug law, if not the outright legalization of drugs, particularly cannabis, than programmes examining the consequences of following such a policy and the harm arising from it. Preventive education campaigns aimed at accurately informing the public in general of the effects of drugs and drug abuse will help to promote a more rational approach to drug problems and to avoid sensationalism.

(...)

It is possible to curb the showing by public broadcasting media, such as the press, radio, film and television, of favourable images of drug abuse. In some countries, it is possible to do this through legislation; in others it can be done through voluntary codes of practice; in still others, however, no

---

[1] UNDCP (2000), *Demand Reduction. A Glossary of Terms*, Vienna: author, page 22.

[2] International Narcotics Control Board (1997) "Preventing drug abuse in an environment of illicit drug promotion." *Annual Report of the International Narcotics Control Board for 1997.* Vienna : INCB, paragraphs 2 and 4.

> *restrictions on promoting drug abuse are in place because freedom of information and freedom of speech are considered to be more important than limiting the promotion of illicit drugs. The Governments of those countries may need to reconsider whether unrestricted access to and the propagation of such information are detrimental to the social and health conditions of their populations.*
> *(...)*
> *Election campaigns have been conducted with candidates standing for parliament on a drug legalization platform. Some campaigns, such as the successful campaigns for the "medical" use of cannabis in Arizona and California in the United States of America, have sought to change the law (...). Such political campaigns need to be met with rational arguments and unambiguous language pointing out the manifold problems that might arise from the decriminalization of drugs and that certainly would arise from the legalization of drugs, in particular the health and economic consequences of such action. (...) The Board notes with regret that despite the fact that (...) Governments of States that are parties to the 1988 Convention are required to make the incitement or inducement to take drugs a criminal offence, either this has not been done or the law has not been enforced.* [3]

If criticisms of the current public policies and demands for alternative approaches are equated with condoning drug use, if prevention means curbing freedom of speech – whether or not one agrees with these critiques – then one has to wonder what prevention is about.

Of course there are, as this chapter will show, many prevention programs that are not aimed solely or even particularly at the prevention of use, but rather the prevention of at-risk behaviour. Harm reduction, for example, is not only a general strategy for dealing with psychoactive substances, but is also a preventive approach that seeks to lower the risks associated with drugs and drug control without requiring abstinence. However, harm reduction is the subject of much controversy and criticism because it is based on the premise that use of drugs is a social reality.

Is law enforcement a preventive measure? Many practitioners, not just police officers, would surely say it is, and they would be right insofar as visible police presence or community policing does have some preventive effect. But in the current context, this is designed to prevent use, not at-risk behaviour, and does so through deterrence, not education or empowerment. And Chapter 14 showed that its effectiveness is very limited. Are sentences, including deprivation of liberty, preventive measures? Of course they are, at least for the time the offender is under supervision or in custody (although drugs are available in prison). But we saw in Chapter 15 that criminalization and penalisation do not deter use. And it is generally admitted that intervention by the justice system is in fact a sign that preventive measures have failed (or were not taken). Are citizenship education, health awareness and self-esteem programs preventive measures? They are indeed, but so, too, are social justice and fairness initiatives, efforts to reduce inequities and measures aimed at improving relations with Aboriginal peoples. If everything is prevention, what, then, constitutes the field of prevention?

[3] *Ibid.*, paragraphs 18, 21, 25 and 27.

Addressing the issue of prevention means considering at the same time government policies on illegal drugs. This is particularly true in the case of cannabis. Preventive messages, as will be seen later, must be credible. The message that smoking tobacco causes lung cancer and cardiovascular disease is credible, at least in part because it is based on a large body of epidemiological studies that have established a strong, statistical cause-and-effect link. The same is true for impaired driving and the wearing of seatbelts. However, as Chapters 6, 7 and 8 have demonstrated, the findings for cannabis are by no means as cut and dried and the weight of the evidence would tend to indicate that it a much less harmful substance than most other psychoactive substances. Contrary to what many told us, marijuana is not illegal because it is dangerous and this is well established in the history of national drug law and international conventions.

The UNDCP glossary also states:

> *Prevention is defined broadly as an intervention designed to change the social and environmental determinants of drug and alcohol abuse, including discouraging the initiation of drug use and preventing the progression to more frequent or regular use among at-risk populations.*[4]

A careful reading of this definition is in order. It says that preventive intervention aims to prevent the abuse of drugs *and* alcohol. In the case of drugs *only*, however, one must aim to prevent people from becoming users in the first place, since drug use will progressively increase. Yet, the research on marijuana does not support this distinction. Alcohol – and before that tobacco – are far more likely than marijuana to lead to more frequent use, even at-risk use, and to be a gateway to other illegal drugs. But alcohol, like tobacco, is legal. Marijuana is not.

Any discussion of prevention entails discussion of the limits of government intervention and of how one conceives of human action. How far should government interventions go in identifying groups at risk without further stigmatizing groups already at risk? To what extent are humans rational beings who act in their best interest provided they are given the right information?

Finally, any discussion of prevention in the Canadian context necessarily has a constitutional dimension: to the extent that preventive measures are matters of health provinces have the primary jurisdiction, and to the extent that prevention is education provinces have exclusive jurisdiction. As we saw in Chapter 12 on the history of federal legislation on illegal drugs, it was no accident that the *Narcotic Control Act* was criminal in nature: since Parliament is authorized to adopt criminal legislation pursuant to the criminal law power conferred by the constitution. The federal government's role in the field of prevention of drug use is limited at best and non-existent at worst *proprio motu*.

This chapter on prevention begins with a statement that will come as no surprise to health or justice experts: when it comes to prevention, there is lots of talk, but the

---

4 *Ibid.*, page 58.

resources allocated are small and the initiatives weak. The second section asks the question: what prevention? We look at current knowledge of the factors underlying prevention initiatives and the effectiveness of some preventive measures, with special emphasis on one of the most important weapons in the war on drugs, the DARE program. The third section looks at the harm reduction approach to prevention. As in the other chapters, our conclusions are in the form of observations that may serve to guide future actions.

INITIATIVES THAT FALL SHORT OF THE MARK

When Canada's Drug Strategy was launched in 1987, the government acknowledged that most federal initiatives had focused on reducing supply and that there had to be more emphasis on prevention. Of the $210 million initially allocated to the first five-year strategy, no less than 32% was earmarked for prevention. In the second phase of the strategy, which ran from 1992 to 1997, the total budget increased to $270 million, with a similar percentage earmarked for prevention.

In 1994, the Government of Canada introduced the National Strategy on Community Safety and Crime Prevention and created the National Crime Prevention Council, now the National Crime Prevention Centre (Department of Justice). When Phase II of that strategy was launched in 1998, funding was $32 million annually; by 2001, funding had increased to more than $65 million. The strategy

> *is aimed at reducing crime and victimization by addressing their root causes through a social development approach. Crime prevention through social development (CPSD) is a long-term, proactive approach. It is directed at removing those personal, social and economic factors that lead some individuals to engage in criminal acts or to become victims of crime. The* National Strategy *is investing in projects that address risk factors in people's lives, such as abuse, violence, poor parenting and drug and alcohol abuse.* [5]

Where do things really stand? The stakeholders are probably in complete agreement that there is a need for prevention. But they are equally unanimous that the actions that have been taken are short of the mark. Otherwise stated, everyone talks prevention, but no one does much about it. The observations made before the Committee cover five sets of considerations: (1) there is not enough prevention; (2) prevention lacks focus; (3) there is not enough evaluation of preventive measures; (4) prevention and social messages about cannabis are contradictory; and (5) there are exemplary practices and successful preventive measures that need to be promoted more widely.

---

[5] National Crime Prevention Centre, statement of objectives, on line at www.crime-prevention.org

Not enough prevention

For many organizations, police departments and government agencies involved in the war on drugs, it is clear that there is not enough prevention. That view is measured in terms of spending levels and cuts in prevention staff.

> *Think of the last time that you saw a drug prevention message on television. Probably one that many of us would recognize is the fried egg commercial representing what happens to your brain. Unfortunately, that was an American ad. I cannot recall a recent anti-drug ad on television. We have produced proactive materials on many other issues in our country. There are campaigns on tobacco and breast cancer. We really have very little material in the drug prevention area. We are not saying that we want more money for policing and arresting people. We agree with the current balance. We think that not only crime prevention, but also drug awareness is a vital tool in making a difference. [...] We believe, first, that there is a role for police in prevention and awareness as well as in enforcement. We have excellent partnerships with teachers, parents and community groups. Community policing has really started to come together in the last 10 years. [...] One of our problems is that some of our programs are dated. Very little effort is put into the prevention aspect. I do not want to be quoted exactly on dollars. However, a report about a year ago indicated that the United States spent about $12 per capita on prevention and awareness. In Canada, the comparative figure was less than $1. I think it was in the area of 20 cents or 30 cents.* [6]

> *Since 1988 and 1989, when we had the* Really Me *campaign, we have had no federal or, in* B.C., *provincial campaign speaking about drugs. [...] When there was a decrease in consistent prevention messages and the National Drug Strategy ended, I witnessed numerous community coalitions and task forces on drugs that dried up and went away and no provincial funding followed it. I watched in Nakusp, Penticton, the Sunshine Coast, Whistler and many other places as excited people were no longer able to keep going because the attention in the country turned to the population health bandwagon. There was a loss of interest, funding levels and prevention, and at the same time, an increase in messages about hemp, "medical marijuana" and other ideas. [...] When you have this going on for years, common sense would tell you we would have some erosion in the gains we had made in consumption. With that, and with some of the changes in drug sentencing and enormous growth in cannabis availability, certainly in British Columbia, it is no wonder we see these changes.* [7]

> [Translation] *Third observation: efforts to prevent substance abuse are clearly inadequate. The task involves budget (increase allocations for prevention in various areas), coordination (provide a better framework for practices in this area) and research (establish clear program evaluation parameters, determine the effectiveness of existing programs, promote winning strategies). There is a particular need for more substance abuse prevention initiatives in the following areas:*

---

[6] Barry King, Chief of the Brockville Police Service, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, March 11, 2002, Issue 14, pages 82-83.
[7] Dr. Colin R. Mangham, Director of Prevention Source B.C., testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, September 17, 2001, Issue 6, pages 74-75.

- *schools (beginning in middle school) and other areas of young people's lives (e.g., streets, parks, youth centres);*
- *workplaces;*
- *front-line services in the health and social services system.*[8]

We had an excellent Canadian program developed in Nova Scotia in conjunction with the Nova Scotia Addictions Foundation known as PACE, the Police Assisted Community Education. We, along with a pharmacist, a doctor, a nurse and some athletes were among the people that went to schools to talk to the students about peer pressure, why some students feel compelled to use drugs, about stealing and different moral ethics, and other subjects relating to drug use. Unfortunately, because of the budget cuts, the programs were cut. The money for evaluations, for increasing the program, or for improving the program no longer exited.[9]

In the 1970s and 1980s, there was support for community-based ongoing prevention efforts. However, in the 1990s, the federal and provincial governments cut a lot of the funding and there has been commensurate rise in drug use. During that same period, multi-faceted prevention efforts such as those directed at tobacco, seat-belts, fire safety, fitness, and dental health, to name a few, made major inroads.[10]

Prevention of social and health problems is often the poor cousin of practice. Whether in health or in justice, the reality is that much more is spent on treatment and intervention after the fact than on prevention. This is true for health issues in general and illegal drugs in particular.

According to the study by Single *et al.*,[11] the direct and indirect cost of illegal drug abuse in 1996 was approximately $1.5 billion. Of that amount, $400 million was spent on law enforcement (police, Customs, courts, correctional services, etc.), and approximately $35 million was spent on prevention, that is, roughly 2% of the total, compared with more than 25% on efforts to fight drugs. Put a different way, the per-capita cost of illegal drugs is roughly $48; by comparison, about $12 is spent on drug control, and about $1 on prevention.[12] **We agree with other stakeholders that spending on prevention is woefully inadequate.**

---

[8] Quebec Standing Committee on the Campaign against Drugs (2000), *Consultation 2000. La toxicomanie au Québec : Cap sur une stratégie nationale*, Quebec City: author, page 13.

[9] Chief Superintendent R.G. Lesser, testimony before the Special Senate Committee on Illegal Drugs, First Session, 37th Parliament, October 29, 2002, Issue 8, page 14.

[10] Art Steinmann, Executive Director, Alcohol-Drug Education Service, testimony before the Special Senate Committee on Illegal Drugs, First Session, 37th Parliament, November 7, 2002, Issue 10, page 86.

[11] Single, E., *et al.* (1996), *The Costs of Substance Abuse in Canada*, Ottawa: Canadian Centre on Substance Abuse.

[12] These figures do not take into account funds allocated to drug abuse prevention by the National Crime Prevention Strategy that was really implemented beginning in 1998.

Prevention lacks focus

Preventing cannabis use probably requires a different approach than preventing the use of heroin or ecstasy. By the same token, prevention of use by students will not be handled the same way as prevention of use by street kids, and preventive measures aimed at Aboriginal youth will be different from those aimed at white youth. We will see in the next section that the risk factors and protective factors are not the same for all social groups.

However, stakeholders point out that prevention messages and the way they are delivered are often inaccurate. We see either universal messages the real effectiveness of which is hard to measure, or messages that are aimed at specific social groups but are not necessarily geared to the reality of the people being targeted.

> [Translation] *Of particular note are weaknesses in secondary prevention. Programs aimed more specifically at high-risk groups are not enough. There is little effective screening where early intervention might make all the difference in preventing problems from getting worse, and this is true not only of youth, but of client groups of all ages. There is at present a lack of consistency in the messages being conveyed and the initiatives being taken. There is a lack of program stability. And in some areas, a great deal of ground has been lost (e.g., gradual loss of substance abuse prevention educators).* [13]

> *Prevention is not 'one size fits all.' Broad population approaches are needed, but so too are narrow focussed activities that target a specific risk group. Of course, prevention is proactive. It promotes personal responsibility. It is highly cost effective: For the cost of one treatment centre, you can fund prevention initiatives that reach hundreds and, indeed, thousands of kids.* [14]

If the focus is prevention, the objectives have to be clarified: is the goal to prevent use, at-risk behaviour or abuse? The chosen preventive measures will be fundamentally different depending on what objectives are set. This point was made in a recent document produced for Health Canada on best practices in the area of prevention:

> *Clear and realistic goals that logically link program activities to the problems and factors found in a community are necessary to guide implementation. Clear and measurable goals will permit evaluation to determine whether the program achieved its objectives. Goals will vary with the community and the circumstances; however, important considerations for all programs are the points at which use and problematic use of different substances generally begin. [...] Accordingly, for youth who are not yet using (i.e., either not considering use or thinking about use) the program aim would be primary prevention. Programs working with a population largely consisting of youth who have initiated use and continue to use, a secondary prevention or harm reduction aim makes most sense. Each of these aims logically lead to*

---

13 Quebec Standing Committee on the Campaign against Drugs, *op. cit.*, page 14.

14 Art Steinmann, Executive Director, Alcohol-Drug Education Service, testimony before the Special Senate Committee on Illegal Drugs, First Session, 37th Parliament, November 7, 2002, Issue 10, page 85.

> *particular activities and messages (e.g., use of more intensive approaches with those using or preparing to use).* [15]

With respect to prevention, there is also a sense that anything and everything is possible by adopting anti-drug rhetoric. However, as we will show in the next section, preventive measures have to zero in more on known risk and protective factors. And because there are many risk factors, preventative action should be multifaceted and involve the community.

There is not enough evaluation of preventive measures

Another reason there is not enough prevention is that no one takes the time or devotes the resources to evaluate programs and demonstrate their effectiveness. As the saying goes, an ounce of prevention is worth a pound of cure. Similarly, one dollar invested in prevention saves five dollars down the road. That may be true, but proving it is something else.

Conducting evaluation studies is not an easy task. If they are to be credible, studies often require a complex methodology. They are also expensive. And most importantly, they cannot – or at least should not – be rushed in order to meet political timelines: to determine, for example, whether a program aimed at preventing drug use among youth is effective, "graduates" have to be monitored for no less than a year (normally at least three years) after they received the program. Canada is not in the habit of doing evaluative research, and, as we saw for Canada's Drug Strategy, we did not set clear objectives or provide the means to evaluate initiatives.

As a result of this situation, prevention – a weak segment if ever there was one – pays the price when even the smallest budget cut is made.

> *One of the biggest problems is that our programs have never had an evaluation component. Whenever we had the opportunity to implement new programs, it was done "quick and dirty." There was very little money. Our only approach was to pump something out and see if it worked. We have all learned that if you are going to do something, do it properly. We should set up new programs with evaluative components in order to know that we are doing the right things at the right time for the right people. In other words, programs should consider the message, the messenger and effectiveness.* [16]

The Committee is of the opinion that any future Canadian drug strategy **will have to include mechanisms and resources to evaluate the various components and in particular to evaluate preventive measures.**

---

[15] Roberts, G., *et al.* (2001), *Preventing Substance Abuse Problems Among Young People. A Compendium of Best Practices*, Office of Canada's Drug Strategy, Health Canada, Ottawa: Supply and Services, pages 30-31.

[16] Barry King, Chief of the Brockville Police Service, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, March 11, 2002, Issue 14, pages 82-83.

Preventive and social messages in contradiction

For some observers, the fact that society has become more tolerant of cannabis in recent years has contributed to increasing levels of use among young people and undermined the prevention efforts.

> *The other important part to remember is acceptability in terms of how drug use is perceived. Even more than availability, acceptability is affected by legal sanctions. When we have sanctions against drugs, it reduces social acceptability and helps hold consumption down. Two aspects of acceptability are perceived risk in using the drug and perceived social acceptance of the drug. Those are two tools we have to keep consumption down.* [17]

> *According to the 1996 Monitoring the Future study by the University of Michigan, today's teens are less likely to consider drug use harmful and risky, are more likely to believe that drug use is widespread and tolerated, and feel more pressure to try illegal drugs than at any other time in the last decade. [...]*

> *The implication of these perceptions is that these factors influence an increase or decrease in the levels of drug use. Legalization of illicit drugs would only weaken these perceptions further. It tells our children that adults believe drugs can be used responsibly. It suggests that there is less risk and that drugs are more acceptable to society. [...] Another influence is the media and the power of communication. Media coverage of individuals smoking marijuana in cannabis clubs tells kids that drug taking can be fun. Within this atmosphere, it is very difficult, if not impossible, to reach children and convince them that doing drugs is harmful. Increased drug availability and drug use will worsen our crime problems. Increased drug use has terrible consequences for our citizens.* [18]

As one American commentator said, telling children that marijuana is a dangerous drug is one thing, but what happens when they find out in high school that their friends are using it without frying their brains? The message probably has to be adapted to the audience, the context and the objectives. However, it is surely just as necessary to tell children and adolescents the truth in prevention programs about drugs, their real effects and about what we still do not know. If our society engages in contradictory debate over cannabis, it is not because some pot activists are manipulating the media; otherwise we would have to question the ability of our media to remain neutral and keep a critical distance. In light of the epidemiological findings presented in Chapter 6 and the scientific research on the effects of cannabis presented in Chapter 7, we believe that **alarmist rhetoric on the effects of cannabis is probably counterproductive for the very people who legitimately hope to prevent its abuse.**

---

[17] Dr. Colin R. Mangham, Director, Prevention Source B.C., testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, September 17, 2001, Issue 6, page 74.

[18] Michael J. Boyd, Chair of the Drug Abuse Committee and Deputy Chief of the Toronto Police Service, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, March 11, 2002, Issue 14, pages 77-78.

That was among the points raised in the recent Health Canada report on best prevention practices.

> *The most important principle for every program, regardless of program goal, is that drug information be scientifically accurate, objective, non-biased and presented without value judgment. [...] Even if younger participants initially accept messages that focus solely on the negative aspects of drug use, once they receive more accurate information, there is a danger that all the messages received earlier will lose credibility. [...] Fear-arousing messages accompanied by incorrect or exaggerated information are not effective, and can generate scepticism, disrespect and resistance toward any advice on substance use or other risk behaviour. [...] Similarly, simplistic messages that young people believe to be unrealistic (e.g., just say 'no') or not feasible (e.g., play sports when there are not facilities readily available) will not be seen as credible.* [19]

There is a body of knowledge on which we have to draw

Without question, there is a widespread preventive practice in Canada that has developed on a trial-and-error basis and is frequently nursed along with limited resources by people who truly believe in it. As we will show in the next section, there is also a body of knowledge on the initiatives that are most likely to have a real effect on risk factors and the processes most likely to support strong preventive measures.

One of the problems is that this "knowledge" all too often remains in the heads of a few people, primarily because few or no evaluative studies are conducted. What studies are done appear in scientific journals and are seen by experts but do not reach practitioners. And there are still few systematic means of disseminating information. This raises the question of how practices proven elsewhere can be adapted to other contexts.

> *We suggest to the Committee that rather than focusing on reforming our drug laws, efforts would be much better spent on examining strategies focused on prevention. Canada's Drug Strategy points out that first and foremost, prevention is the most cost-effective intervention. If we know that to be true, should we not focus our attention on tactics that will ensure greatest possible return on our investment? [...] In a compendium of best practices by the Canadian Centre on Substance Abuse, the authors draw attention to the importance of parental influence in high-risk behaviour among youth. [...] Numerous studies completed at the Center on Addictions and Substance Abuse at Columbia University which include extensive research into prevention programs, have reached the same conclusion.* [20]
>
> *Finally, in our years of work and prevention we have come to understand that the real problem is not so much a drug problem as a people problem. That is, all people - especially kids who have suffered abuse, neglect, trauma, and addiction in the home - seek ways to deal with their feelings of anger, despair, hopelessness or powerlessness. Some may have feelings of boredom, curiosity or a desire to belong.*

---

[19] Roberts, G., *et al.* (2001), *op. cit.*, page 40.

[20] Brief from the Focus on the Family Association to the Special Senate Committee on Illegal Drugs, May 14, 2002.

Marijuana and other drugs can seem to solve or at least soothe these emotions. [...] Alternatively, there is great potential through prevention to foster informed, confident, capable young people, who from the earliest ages learn sound mental health practices that are drug-free ways to manage these pressing and understandable human feelings. [21]

PREVENTING WHAT AND HOW?

Agreeing on the need for prevention is a bit like agreeing on the importance of virtue. Yet, as we saw in the introduction to this chapter, whether we all agree on the very concept of prevention is not all that clear. The United Nations Office for Drug Control and Crime Prevention glossary defines prevention as follows:

Prevention activities may be broad-based efforts directed at the mainstream population(s), such as mass general public information and education campaigns, community-focused initiatives and school-based programs directed at youth or students at large. Prevention interventions may also target vulnerable and at-risk populations, including street children, out-of-school youth, children of drug abusers, offenders within the community or in prison, and so on. Essentially, prevention addresses the following main components:

- *Creating awareness and informing/educating about drugs and the adverse health and social effects of drug use and abuse, and promoting anti-drug norms and pro-social behaviour against drug use;*
- *Enabling individuals and groups to acquire personal and social life skills to develop anti-drug attitudes and avoid engaging in drug-using behaviour;*
- *Promoting supportive environments and alternative healthier, more productive and fulfilling behaviours and lifestyles, free of drug use.* [22]

What this means, then, is taking initiatives that alter the factors leading to drug abuse, where all use is abuse in the case of an illegal substance or a substance controlled by international conventions. The definition identifies as a factor in abuse first-time use of drugs, on the premise that introduction – at least in people considered to be "at risk" – leads to more frequent use or use of other substances. The proposed areas of action indirectly identify other factors: the absence of information on the adverse effects of drug use and social norms that are insufficiently anti-drug, inadequate personal and social skills to resist drug use, and unsatisfactory lifestyles that are not health oriented are other factors in drug abuse.

But what do we know about the reasons why people use drugs, marijuana in particular? We know that men use more alcohol and drugs and that women use more prescription drugs. Do we really know why? We think that there may be more than

[21] Art Steinmann, Executive Director, Alcohol-Drug Education Service, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, November 7, 2002, Issue 10, page 90.

[22] UNDCP (2000), *op. cit.*, page 58.

150 million marijuana users in the world, and we have said that there are approximately 3 million a year in Canada; are we to conclude that those people lacked the personal and social skills needed to resist drugs? When, at what point, does use become a problem? Depending on the answers to those questions, the entire prevention strategy will be different.

Genetic baggage aside, public health factors are a function of:

> [Translation] *[...] environmental factors related to the setting in which the person lives, from conception to death: the social as well as the physical environment. Education, employment, income, family and social relationships, and distribution of wealth are all factors that come into play. There is a close link between socio-economic status and health and well-being: that link is confirmed by data on hospitalization, disability, health problems and mortality in a given population. Other factors of course include lifestyle and behaviour, such as tobacco use and diet. Even though these are factors that can be changed and are often targeted by prevention, they are also largely conditioned by socio-economic factors. The last factor is health services, the level and organization of which vary from community to community and country to country.*[23]

It is true that epidemiological data tend to show that young marijuana users are more likely to be from disadvantaged socio-economic backgrounds, are more likely to smoke tobacco, and probably have parents who smoke or even use marijuana. These are referred to as environmental risk factors. According to some authors, regular or heavy users, those who are at risk, also suffer low self-esteem, are more likely to drop out of school or not finish high school, and do not perform as well academically. These are personal risk factors.

Another term in the vocabulary of prevention besides "risk factor" is "protective factor". The United Nations Office for Drug Control and Crime Prevention defines "protective factor" as follows:

> *A factor that will reduce the probability of an event occurring which is perceived as being undesirable. This term is often used to indicate the characteristics of individuals or their environments, which reduce the likelihood of experimentation with illegal drugs. For example there is some evidence from research in developed countries that each of the following are, statistically at least, protective in relation to illicit drug use: being female; of high socio-economic status; being employed, having high academic attainment; practising a religion; and being a non smoker.*[24]

Epidemiological data show that use is lower among women, non-smokers and people who practise a religion. However, the data are not as clear in terms of the impact of socio-economic status or level of schooling.

---

[23] Public Health Directorate, *Les inégalités sociales de la santé. Rapport annuel 1998 sur la santé de la population.* [social inequity in health; 1998 annual report on public health], Montreal: Régie régionale de la santé et des services sociaux de Montréal-Centre.

[24] UNDCP, *op. cit.*, page 60.

One of the key works in the literature on prevention is without question the 1995 research by Hawkins *et al.*[25] The authors give a comprehensive list of risk factors related directly or indirectly to drug abuse, divided into five categories: individual, family, school, peer and community environment. These factors were identified based on a series of longitudinal studies that tracked children and adolescents over long periods.

> *Recent longitudinal research has identified risk and protective factors in the individual and the environment that consistently predict drug involvement. Moreover, the evidence indicates that the likelihood of drug abuse is higher among those exposed to multiple risk factors and that the risk of drug abuse increases exponentially with exposure to more risk factors. The higher rates of drug abuse among criminal and homeless populations are consistent with studies of personal, social and environmental risk factors that are predictive of substance abuse. This line of research suggests that intervention to prevent drug abuse should focus on reducing multiple risk factors in family, school, peer, and community environments.* [26]

1. *Individual factors*

The authors include among the individual factors identified by the research family history, genetic history, biochemical characteristics, early and persistent behavioural problems, alienation and rebelliousness, attitudes favourable to drug use, and early introduction to drugs.

2. *Family factors*

These factors include parents who use or permit the use of substances, poor parenting, poor parent-child relationships and family conflict.

3. *School factors*

These factors include academic failure and a weak commitment to school; intelligence is not a factor, but the school environment and learning difficulties have a determining effect.

4. *Peer factors*

Peer rejection in primary school and peers who use drugs are also factors related to substance abuse.

5. *Environmental factors*

The availability of drugs, legal and cultural norms, poverty and an unstable living environment.

---

[25] Hawkins, D.J., M.W. Arthur and R.F. Catalano (1995), "Preventing Substance Abuse" in Tonry, M., and D.P. Farrington (eds.), *Building a Safer Society: Strategic Approaches to Crime Prevention.* Chicago: University of Chicago Press.

[26] Hawkins, D., *op. cit.*, page 368.

The authors identify as protective factors individual characteristics (resilience, social and personal skills, intelligence), the quality of childhood relations in the family and especially at school, and individual and social objection to drug use.

These factors must not be confused with causes. They are statistical links that are themselves limited by methodological problems related to measurement of behaviour, evaluation of the impact of intervention, and other considerations.[27]

> *A clear advantage of the protective/risk factor approach is the understanding that many social and health problems are linked by the same root factors – an understanding that can lead to better integration of strategies and economizing of resources. However, because a factor is linked to substance use problems does not necessarily mean that it causes such problems. Consequently, the actual preventive effect of addressing one or another of the protective or risk factors is not very clear and no doubt varies between the factors. Nevertheless, it appears that addressing protective or risk factors in several domains of a young person's life (i.e., individual, school, family and community) can lead to positive outcomes.*[28]

Hawkins *et al.* reviewed a series of initiatives–prenatal and neonatal, and preschool, primary school and secondary school–that were evaluated. They found that the most promising strategies are multidisciplinary approaches involving the community.

> *The evidence suggests that multistrategy approaches that address multiple risks while enhancing protective factors hold the most promise for preventing substance abuse. The current challenge for substance abuse prevention research is to test prevention strategies that empower communities to design and take control of their own efforts to explicitly assess, prioritize, and address risk and protective factors for substance abuse.*[29]

Prevention is not, however, a formula that can be used over and over in the exact same way. The characteristics of local communities, existing social relationships, and the strength of community organizations are among the factors that play a key role in the success of preventive measures. There is growing consensus among authors on a series of steps that are most likely to bring about success. The compendium of best practices published by Health Canada proposes the following:

- Build a strong framework
  - Address protective factors, risk factors and resiliency
  - Seek comprehensiveness
  - Ensure sufficient program duration and intensity
- Strive for accountability
  - Base program on accurate information
  - Set clear and realistic goals

---

[27] Hawkins D., *et al.*, *op. cit.*, pp. 363-367.

[28] Roberts, G., *et al.* (2001), *op. cit.*, page 24.

[29] Hawkins, D., *et al.*, *op. cit.*, page 404.

    - Monitor and evaluate the program
    - Address program sustainability from the beginning
- Understand and involve young people
    - Account for the implications of adolescent psychosocial development
    - Recognize youth perceptions of substance use
    - Involve youth in program design and implementation
- Create an effective process
    - Develop credible messages
    - Combine knowledge and skill development
    - Use an interactive group process
    - Give attention to teacher or leader qualities and training

What actions are proven and promising? The compendium lists a number of Canadian intervention programs, but none has really undergone comprehensive evaluation.

A number of people who spoke at our hearings, police officers in particular, mentioned the DARE (Drug Abuse Resistance Education) program.

> *We use a revised, Canadian version of DARE, which is not the program most people have been hearing about for years. We are achieving success and acceptance with it.*[30]

> *We were unable to continue to fund Canadian programs, and to the credit of the RCMP and its members across the divisions, they turned to DARE, the Drug Abuse Resistance Education, from the United States. It was a pre-made, off-the-shelf program. Our budget still does not permit us to develop Canadian programs or to do evaluations. Unfortunately and embarrassing is that of the money that has gone to teaching Canadian police officers to instruct, a total of $750,000 has been paid for by the United States. The Canadian government has not funded any DARE training.*[31]

DARE was introduced in the United States in the early 1980s by the Los Angeles Police Department. In 1996, the program was being used by 70% of school districts and was serving 25 million students. Some 25,000 American police officers were trained to deliver the DARE program in schools. DARE is also used in 44 other countries around the world. It includes a number of modules delivered in different ways depending on the community. Basically, it entails a series of visits from kindergarten to grade four in which the children are given short lessons on personal safety, respect for the law, and drugs. The main 17-week program is designed for students in grades five and six. A 10-week program for middle-school students focuses on resistance to peer pressure, the ability to make personal choices, conflict resolution and anger management. Another 10-week program for high-school students focuses on personal

---

[30] Barry King, Chief of the Brockville Police Service, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, March 11, 2002, Issue 14, page 83.

[31] Chief Superintendent R.G. Lesser, testimony before the Special Senate Committee on Illegal Drugs, First Session, 37th Parliament, October 29, 2002, Issue 8, page 14.

choices and anger management. Finally, DARE+ is an after-school program for high-school students built around recreational activities. The main 17-week program for grades five and six is the one most frequently used (81% of American school districts). It is delivered by a uniformed police officer and focuses on the ability to resist drugs. It provides information on drugs and their effects, self-esteem, and alternatives to drugs. The program includes lectures, group discussions, audio-visual presentations, exercises and role playing.

A document we received from the RCMP shows that the DARE Program is being taught in 1,811 schools in 584 different communities in Canada outside Quebec. Alberta leads the way with 150 school districts, 583 schools and more than 21,400 students in 2001, followed by Ontario (40 districts, 346 schools, 10,940 students) and British Columbia (60 districts, 289 schools, 10,800 students). All these schools offer the main 17-week program. In 2001, the program served more than 53,000 students. In all, the various components of the DARE program reached more than 65,000 Canadian students in 2001.

We do not know how much the program has been "Canadianized". To our knowledge, there have been no studies to evaluate the program's impact. The document we received is the first phase of an evaluation study that should, in the second phase, provide data on impact. The first phase of the study deals with students', teachers' and parents' opinions, preferences and perceptions.[32] The study looked at all of the grade 5 and grade 7 students in the West Vancouver school district who took the program (500 and 570 students, respectively), as well as their parents and teachers. The findings showed a very high level of satisfaction with the program:

- 97% of the students, 95% of the teachers and between 78% and 94% of the parents, depending on the grade, were in agreement with the program and the program objectives;
- 78% of the teachers agreed with the content of the DARE program for their grade level;
- 72% of the students felt that the information they received was valid and up to date;
- 97% of the teachers were very satisfied with the relationship between the police officer delivering the program and the students;
- 96% of the students said they understood the message;
- 88% of the students said that DARE had helped them resist drugs in middle school; the result was 58% in high school;
- between 82% and 89% said that they had a better understanding of the dangers of drugs.

These are only some of the findings. The data are in line with what can be found on the DARE's U.S. Internet site and in a number of evaluations. However, those evaluations measured opinions, perceptions and attitudes, not behaviour. To some extent, these results, positive though they may be, are not really surprising.

---

[32] Curtis, C.K. (1999), *The efficacy of the Drug Abuse Resistance Education program (DARE) in West Vancouver schools. Part 1 – Attitudes toward DARE: An examination of opinions, preferences, and perceptions of students, teachers, and parents*, West Vancouver RCMP.

In contrast, almost all of the evaluations that have endeavoured to measure the impact of the DARE program on behaviour, specifically the prevention or reduction of drug use, have shown that the program had no impact or, at best, very little and very short-term impact.

The compendium of best practices produced for Health Canada contains a separate section on the DARE program which states in part:

There have been many D.A.R.E. reviews and evaluations, but few rigorous scientific evaluations. While some evaluations show positive results, studies published in peer reviewed journals, including a 5-year prospective study and a meta-analysis of D.A. R.E outcome evaluations, have been consistent in showing that the program does not prevent or delay drug use, nor does it affect future intentions to use. On the positive side, it does seem to boost anti-drug attitudes, at least in the short-term, increase knowledge about drugs and foster positive police-community relations. Also, acceptance of the program is generally quite high among police presenters, students and their parents. [33]

Of course, the absence of program impact can be attributed to the requirements of the evaluation. However, these requirements are the same as those used for other program evaluations.

In 1997, a major report on what works, what does not work and what is promising in the area of crime prevention was tabled in the United States Congress; Congress had commissioned the report from a team of prominent researchers at a number of American universities.[34] The report had the following to say about the DARE program:

Several evaluations of the original 17-lesson core have been conducted. Many of these are summarized in a meta-analysis of DARE's short-term effects sponsored by NIJ [National Institute of Justice]. This study located 18 evaluations of DARE's core curriculum, of which 8 met the methodological criterion standards for inclusion in the study. The study found:

1. *Short term effect on drug use are, except for tobacco use, non significant;*
2. *The sizes of the effects on drug use are slight. Effect sizes average .06 for drug use and never exceed .11 in any study. The effects on known risk factors for substance use targeted by the program are also small: .11 for attitudes about drug use and .19 for social skills.*
3. *Certain other programs targeting the same age group as DARE [...] are more effective than DARE. [...]*

Four more recent reports, three of them longitudinal, have also failed to find positive effects for DARE. Lindstrom (1996), in a reasonably rigorous study of approximately 1,800 students in Sweden, found no significant differences on measures of delinquency, substance use, or attitudes favoring substance use between students who did and did not receive the DARE program. Sigler and Talley (1995) found no difference in the substance use of seventh grade students in Los Alamos, New Mexico who had and had not received the DARE program 11 months before. Rosenbaum et coll. (1994) report on a study in

---

[33] Roberts, G., *et al.*, *op. cit.*, page 171.

[34] Sherman, L.W., *et al.* (1997), *Preventing Crime: What Works, What Doesn't, What's Promising.* A Report to the United States Congress, Washington, DC: US Department of Justice.

> *which 12 pairs of schools (involving nearly 1,600 students) were randomly assigned to receive or not receive DARE. Although some positive effects of the program were observed immediately following the program, by the next school year no statistically significant differences between DARE and non-DARE students were evident on measures of the use of cigarettes or alcohol. [...] These studies and recent media reports have criticized DARE for (a) focusing too little on social competency skill development and too much on effective outcomes and drug knowledge; (b) relying on lecture and discussion format rather than more interactive teaching methods; and (c) using uniformed police officers who are relatively inexperienced teachers and may have less rapport with students.*
>
> *[...]*
>
> *In summary, using the criteria adopted for this report, DARE does not work to reduce substance use. [...] No scientific evidence suggests that the DARE core curriculum, as originally designed or revised in 1993, will reduce substance use in the absence of continued instruction more focused on social competency development.* [35]

This information is in the public domain. It has been available for many years. Considering the limited resources available for the prevention of drug abuse in Canada, federal authorities and the RCMP ought to have looked at that information before deciding to implement even a Canadian version of the DARE program. Beyond the rhetoric that may please some, there are in this case–and this is so rare that we must take advantage–comprehensive studies which show that the program is not meeting its stated goals.

The same study identifies other programs that are much more likely to have a positive impact on drug use and abuse, in particular programs that develop social skills. The Canadian compendium also describes a number of programs that have undergone equally comprehensive evaluation and have shown positive results.

Like one of our witnesses, we seriously question the police-led practice used to deliver drug education in schools:

> *I have a quick aside about police-led drug education. We, personally, have some concerns with police officers teaching many hours of drug education in the classroom. We do not think it is sustainable financially to have paid police officers in at every grade level teaching hours and hours of drug education. Teachers - classroom teachers - are trained to be educators and that includes how to build self-esteem, how to make kids feel more capable. In addition, we know there are good, well-intentioned police officers, but our concern is that some of them do not, in our view, have sufficient training to do the type of education that is required. I am also concerned that the DARE program in the United States is now starting a whole new initiative. [...] they still are not addressing a very fundamental question, which is, 'who is the best person to deliver these?'*
>
> *We have heard concerns from students and teachers that police-led drug education can be more authoritarian and that it can come across not so much as helping kids to make their own carefully thought out choices, but more to lead them into one specific choice.* [36]

---

[35] *Ibid.*, pages 5-33 to 5-35.

[36] Art Steinmann, Executive Director, Alcohol-Drug Education Service, testimony before the Special Senate Committee on Illegal Drugs, First Session, 37th Parliament, October 29, 2002, Issue 10, page 86.

We believe that there is a need for **education about psychoactive substances, forms of use and the related risks. But we also believe that there is a need to rethink the approaches being used and that police officers, if they must be involved, should neither develop the programs nor deliver them to students.**

Lists of risk and protective factors and of successful programs aside, it is key to have a holistic vision of prevention, because drugs are part of a complex social, cultural and historical environment. Analysis of the debate over prevention and prevention practices shows that one of the risks lies in putting forward a reductionist and mechanistic view of personal and community health. We observed in Chapter 6 that the available data showed an increase in marijuana use among high-school students. We also saw in Chapter 10 that public opinion is perhaps more tolerant than it used to be. And we have seen in this chapter that little has been done in the area of prevention. Does this mean, as the Canadian Centre on Substance Abuse has said, that the increase in use is merely the result of all these factors combined?

> *The resurgence of drug use we are now witnessing is led largely by mainstream youth, indicating that we may have paid a heavy price for changing our focus and neglecting this group in Phase II* (of Canada's drug Strategy). *Ultimately we must aim our prevention messages at all youth. The Centre believes that all young people-drop-outs and A students alike-are vulnerable to drug use and should be viewed as an at-risk population.* [37]

Is it really the effect of the prevention initiatives taken in the first phase of the strategy (1987-1992) that accounts for the relative decline in use during that period? Is it really the absence of debate and prevention practices in the 1990s that accounts for the increase in use? Strictly speaking, no one knows. Not only was there no evaluation of the first phase of the national strategy, but even the most comprehensive evaluation might not have been conclusive. The increase in use in the 1990s could just as easily have been the result of a series of entirely different factors, such as cutbacks in government services, the decline in the youth labour market or even globalization of world markets, which makes people feel powerless to change their living conditions. There might even be other factors of which we are not yet aware.

In the United States, the use of illegal substances decreased between 1982 and 1991, then started to rise again in 1993. Did policies and approaches change? Incarceration rates for drug-related crimes certainly did not drop. At least as much money was spent on prevention and education programs. The rate of alcohol use among youth under 17 also decreased; can that be attributed to the same factors? Inversely, the proportion of smokers in the population hardly changed at all despite equally or more aggressive awareness and prevention campaigns. What do we make of this? The decrease in illegal drug use may be attributable in part to "war on drugs"

---

37 Canadian Centre on Substance Abuse (1996), *Canada's Drug Policy. Brief to the Standing House of Commons Committee on Health*, Ottawa: author.

policies, but that is by no means a completely satisfactory explanation. And we also have to consider the social and economic cost.

> *The U.S. government's 'War on Drugs' resulted in a tremendous expansion of resources applied to supply reduction and interdiction efforts focused on illegal drugs and in increasingly harsh criminal sanctions against users, including those caught in possession of relatively small amounts of illegal drugs. These policies have apparently had little effect on the availability of addictive drugs or on reducing abuse. They have fueled higher costs associated with prison construction and a tremendous increase in the prison population, leading some to call for legalization of currently proscribed drugs such as marijuana and cocaine.* [38]

Through all of this, there is little room for a less mechanistic view of individuals. We were reminded of this by J.F. Malherbe in the paper he wrote at our request:

> *The human experience is always complex and multifactorial, and no statement of risk referring to a single factor has any meaning for an individual subject (even though certain correlations appear to be well established). The future cannot be predicted for a singular individual on the basis of statistical information. We can therefore wonder at times about the level of scientific training (or honesty) of doctors who confuse "statistical correlation" with "risk factors" and "causes". It is true, however, that it is more convenient to "preach" to people about the causes of cancer than to support and inform them in the often chaotic advance of their freedom toward fuller responsibility for themselves, for others and for the fragile biosphere to which we belong.* [39]

Professor Malherbe went on to say:

> *The true harm, the worst of all, the most intolerable, the only one that must absolutely be repressed is wanting to make people happy by deepening their fear of disease and death, without asking each individual to make personal choices and realize his or her preferences. The true, the only harm stems from health ideology, from the* furor sanandi, *which sketches out our happiness without us being able to enjoy it.*
> *Does this mean that everything should be permitted without distinction? Of course not. But the test is still to discover step by step through our trials and errors, and it cannot be imposed on us by experts – doctors or economists – in the name of a prior and death-causing order. The joy of fertile disorder is better for life than the boredom of a type of planning, the arbitrary nature of which equals nothing but sterility.* [40]

---

[38] Hawkins, D.J., M.W. Arthur and R.F. Catalano (1995), "Preventing Substance Abuse", in Tonry, M., and D.P. Farrington (eds.), *Building a Safer Society: Strategic Approaches to Crime Prevention, Chicago: University of Chicago Press,* page 344.
[39] Malherbe, J.F. (2002), *The contribution in defining guiding princples fr a public policy on drugs.* Document prepared for the Special Senate Committee on Illegal Drugs, Ottawa: Senate of Canada, page 7.
[40] *Ibid.*, page 10.

Moreover, prevention, especially in schools, must provide a forum for open discussion that makes young people accountable and permits the acculturation of substances. Demonization and indoctrination can never take the place of education.

RISK REDUCTION AND HARM REDUCTION

The harm reduction approach has become a preferred tool in preventing AIDS/HIV contamination through intravenous drug use. It was discovered in the late 1980s that IV drug users were a key vector for the transmission of HIV. Needle exchange programs came about as a result.

However, the harm reduction approach creates a number of conceptual and theoretical problems. The first problem is terminology. "Harm reduction" is the term most commonly used in English, but "risk reduction" is also sometimes used. In French, "harm reduction" has been rendered as "*réduction des méfaits*", but also as "*réduction des dommages*" and "*réduction des risques*".

Further, the concept and practice of harm reduction have been criticized by some observers who see them as veiled strategies for legalizing drugs.

> *When I say a 'harm reduction drug policy,' I do not mean as we have already initiated in the response to drugs so far. We have tried many things such as needle exchanges and we have tried a harm reduction approach to drinking and driving. I have developed many programs for youth, which is my specialty. If I were called upon to develop a program to teach youth with any certainty about how to use drugs that are now illegal in a safe and moderate way, I do not think I could do so. Drugs fundamentally have effects. They do affect us. For example, it may be the cleanest heroin in the world, but is the person functioning in the family and at work, and are they able to pay for the habit that they will develop? Those are questions that need to be answered.*
>
> *When I use the term, I mean harm reduction as it has been promoted. The term has become sullied, unfortunately. It began as a noble thing, but has become a key code word for decriminalization or legalization of substances. I would caution you against using the term as it is.* [41]

Granted, harm reduction strategies are often on a collision course with law enforcement strategies: the situation has arisen often in cities across Canada where heroin addicts leaving needle exchange clinics come face to face with police.

The term "harm reduction" refers more specifically to strategies aimed at reducing the adverse effects of drug use on health, economic status and the social environment for users and those around them.[42] In addition to needle exchange, harm

---

[41] Dr. Colin Mangham, page 73.

[42] See, for example, the work of D. Riley (1996), *Harm Reduction: Concepts and Practice. A Policy Discussion Paper*, Canadian Centre on Substance Abuse, and the discussion paper Dr. Riley prepared for Senator Nolin.

reduction strategies for drug users include such measures as prescription methadone for heroin addicts, medically supervised prescription heroin programs and "safe injection rooms", or clinics where no prescription is required. Canadian stakeholders agree that these measures are underdeveloped in Canada. Health Canada recently announced that a prescription heroin program would be tested in three major cities. The number of methadone places is said to be insufficient. Moreover, there are no safe injection rooms.

What are the implications of a harm reduction strategy for cannabis? What applications might there be for such a strategy? Harm reduction strategies related to heroin, for example, have been based on knowledge of some of the harmful effects of injecting the drug: HIV and hepatitis C for users (needle exchange programs), unsanitary conditions and risk of violence in places where the drug is injected (safe injection rooms), and petty property crime to get money to buy drugs (prescription heroin). In order to develop harm reduction strategies, we therefore have to know at least something about the ways the drug is used and its direct and indirect harmful effects. What are the harmful effects of cannabis?

We identified some of those harmful effects in Chapters 7 and 8. They include:

- risks for youth under 16 because of their physiological immaturity, in particular the immaturity of their endogenous cannabinoid system;
- risks associated with use that could be described as "occupational" (as opposed to recreational): the person uses marijuana alone, in the morning, to do school work or to carry out a job;
- risks associated with heavy, frequent use over a long period;
- risks associated with inhalation over a long period;
- risks associated with impaired driving, especially when the marijuana is mixed with alcohol.

Based on this knowledge, harm reduction strategies could be developed for cannabis:

- discourage use by youth under 16;
- detect at-risk users, especially among youth;
- provide information on the risks of inhaling and point out that deep inhalation is part of the folklore and is not necessary to obtain the effects;
- use strong measures to discourage impaired driving.

Obviously, like harm reduction strategies for other drugs, these tools are based on recognition of use and an approach that does not call for abstinence. We know full well that these two points may elicit strong reactions from those who believe that cannabis is fundamentally dangerous and may put us at odds with the current legal context.

CONCLUSIONS

Prevention is necessary. Keeping our guiding principles in mind, prevention must be part of a vision of the role of governance as a way of fostering human initiative and a vision of ethics and public health that focus on autonomy. In that sense, it is not an instrument of control, but rather a tool to help set people free. And in the case of cannabis, being set free does not mean not using, but rather having the ability to take a position on and think about the reasons for using and the ability to deal independently with at-risk behaviour.

Conclusions – Chapter 16	
On prevention	➢ **A national drug strategy should include a strong prevention component.** ➢ **Prevention strategies must be able to take into account contemporary knowledge about drugs.** ➢ **Prevention messages must be credible, verifiable and neutral.** ➢ **Prevention strategies must be comprehensive, cover many different factors and involve the community.** ➢ **Prevention strategies in schools should not be led by police services or delivered by police officers.** ➢ **The RCMP should reconsider its choice of the DARE program.**
On evaluation	➢ **Prevention strategies must include comprehensive evaluation of a number of key measurements.** ➢ **A national drug strategy should include mechanisms for widely disseminating the results of research and evaluations.** ➢ **Evaluations must avoid reductionism, involve stakeholders in prevention, be part of the program, and include longitudinal impact assessment.**
On harm reduction	➢ **Harm reduction strategies related to cannabis should be developed in coordination with educators and the social services sector.** ➢ **Harm reduction strategies related to cannabis should include information on the risks associated with heavy chronic use, tools for detecting at-risk and heavy users, and measures to discourage people from driving under the influence of marijuana.**

CHAPTER 17

TREATMENT PRACTICES

With the exception of the treatment given to offenders imprisoned in federal institutions and Aboriginals, the care available to individuals who are substance-dependent is essentially the responsibility of the provinces and territories. This chapter will therefore be brief since we received only a few submissions and heard few witnesses on this question.

In order to place the discussion in context, we should begin by noting certain data concerning dependency induced by cannabis and its derivatives. We shall then examine the various forms of treatment that are available. Finally, we shall take a brief look at the state of knowledge concerning the effectiveness of these treatments.

CANNABIS DEPENDENCY

Let us first clarify the terminology. We saw in Chapter 7 that, while the word addiction is used most often to refer to those who have a problem of dependency on psychoactive substances, the WHO recommended as long ago as 1963 that this expression not be used because of its vagueness. We prefer to use the term dependency for at least two reasons. First, it is more encompassing and may include different types of addictive behaviour: substance-related (food, alcohol, illicit drugs) and activity-related (gambling, sex, extreme sports, etc.). In the cases of substances, it is also more specific, referring to both the physical and psychological components of dependency. We share the distinction made by the WHO between physical and psychological dependency:

> [Translation] … *psychic dependency is a 'state in which a drug produces a feeling of satisfaction and a psychic urge that requires period or ongoing administration of the drug in order to cause pleasure or to avoid discomfort'.*
> *Physical dependency is an 'adaptive state marked by the appearance of intense physical problems when the administration of the drug is delayed or its action is counteracted by a specific antagonist. These*

problems, that is the symptoms of withdrawal or abstinence, consist of symptoms and signs of a physical or mental nature that are characteristic of each drug. [1]

And third, it is a more neutral term. While dependency is described as a state induced by the prolonged and abusive consumption of a substance, addiction has a connotation of mental illness, indeed a moral connotation. Some authorities such as NIDA, for example, do not hesitate to classify addiction as a true illness that has certain genetic components. Seen in this way, drug use triggers biophysiological mechanisms that lead to addiction. Hence the focus on abstinence. Treatment programs in Canada tend to regard dependency as a bio-psychosocial phenomenon; "*[h]owever, support for the various modifications of the disease model continues in some service sectors*".[2] It is interesting to note that more rehabilitation programs for alcoholism (51%) than programs for 'addiction' (47%) accept a harm-reduction strategy and thus objectives other than abstinence.[3]

These precisions made, the Committee noted the ambivalence in the terminology, depending on the language. The English name of the *Centre canadien de lutte contre l'alcoolisme et la toxicomanie* [Canadian centre for the battle against alcoholism and addiction] is the Canadian Centre on Substance Abuse (centre canadien sur l'abus des substances). The French title of the brochure published by the Department of the Solicitor General describing the Department's activities is *La lutte contre la toxicomanie* [the battle against addiction] while the English title is *Countering Substance Abuse* (combattre l'abus de substances). The name of a government organization in Quebec is the *Comité permanent de lutte à la toxicomanie* [standing committee on the battle against addiction]. In addition to projecting a strong moral thrust, the French word "*toxicomanie*" evokes a vocabulary of struggle and combat, whereas the term substance abuse is more neutral and we might even go so far as to say more measured. However, the difference between the two languages cannot be explained by the lack of an appropriate noun in French: *dépendance* is the equivalent of drug addiction, and some in French even use the term addiction. A little rigour and clarity would be beneficial in light of the emotion surrounding the debate about drugs.

Having distinguished between use, at-risk use and excessive use, we feel that we should logically avoid the term drug addiction to refer to dependency induced by excessive use. Moreover, federal government departments and agencies should modify their terminology and ensure that both language versions are in accordance.

How common is cannabis dependency? In Chapter 7 we determined that physical dependency on cannabis was definitely rare and insignificant. Some symptoms of

---

[1] WHO (1964), *Comité d'experts des drogues engendrant la dépendance*, Technical Reports Series, No. 273, quoted in Caballero and Bisiou, *op. cit.*, pages 5-6.

[2] Roberts, G. and A. Ogborne (1998), *Profile: Substance Abuse Treatment and Rehabilitation in Canada*. Ottawa: Canada's Drug Strategy, Department of Health, page 20.

[3] *Ibid.*

addiction and tolerance can be identified in habitual users but most of them have no problem in quitting and do not generally require a period of withdrawal.

As far as forms of psychological dependency are concerned, the studies are still incomplete but the international data tend to suggest that between 5% and 10% of regular users (at least during the last month) are at risk of becoming dependent on cannabis. If we recall that approximately we estimated that approximately 3% or 600,000 adult Canadians have consumed cannabis in the last month and that approximately 100,000 or 0.5% use it on a daily basis; this indicates that somewhere between 30,000 and 40,000 might be at-risk and 5,000 to 10,000 might make excessive use. For 16 and 17 years old, the numbers were between 50,000 and 70,000 at-risk and 8,000 to 17,000 potentially excessive users. The data also indicated that the peak period for intensive use is between 17 and 25 years. These broad parameters indicate where to look to prevent dependency and offer treatment services for those in need.

What form does cannabis dependency take? Most of the authors agree that psychological dependency on cannabis is also relatively minor. In fact, it cannot be compared in any way with tobacco or alcohol dependency and is even less common than dependency on certain psychotropic medications. Ceasing to consume the substance for two to four weeks, which can be accompanied by certain symptoms similar to those involved in nicotine withdrawal (insomnia, irritability, perspiration, etc.), is usually sufficient to cause the symptoms to disappear. When treatment is necessary, in the case of some people, it does not take as long as and is less difficult than the corresponding treatment for dependency on alcohol or "hard" drugs. It is also worthy of note that those seeking treatment for cannabis dependency are younger than those who receive treatment for dependency on other drugs. A number of factors may explain this situation: consumption of cannabis is more a phenomenon of youth than that of other substances, reaching its peak when young people are in their early twenties and declining significantly when they reach their thirties. Young people who need treatment also display problems of multiple addiction since cannabis is not the only drug they consume.

Overcoming dependency or consumption that the user regards as abusive is often a matter of personal choice and does not necessarily require therapeutic intervention.

> *There is the phenomenon called spontaneous remission. Many people, when they get into their thirties either stop using drugs altogether or tone down their habit. There is an obvious phenomenon of maturity in terms of drug use.*
>
> *Among long-term users, we also see the retirement phenomenon, that is these individuals become fed up of their drug-using lifestyle. These individuals lose interest in the ongoing quest for drugs and for the pleasure that these drugs can provide them. In fact, it can be equated with a type of cost benefit analysis, whereby as the individual gets older, he/she decides that the habit is no longer worth it. The individual considers that the negative impact of his/her habit is no longer worth it.*[4]

[4] Dr. Céline Mercier, testimony before the Senate Special Committee on Illegal Drugs, Senate of Canada, Thirty-Seventh Parliament, First Session, December 10, 2001, Issue 12, page 9.

> *While most people who experience substance abuse problems do not receive help, there is good evidence that people exposed to some types of treatment subsequently reduce their use of psychoactive substances and show improvement in other life areas. In general, treatment outcomes are improved when appropriate treatments are also provided for significant life problems (communications problems, lack of assertiveness, unemployment).* [5]

There is every reason to believe that, as far as cannabis is concerned, most problem users do not make use of the various forms of treatment and probably do not need any, firstly because the effects of cannabis are not as marked as those of other drugs and secondly, because cannabis users are more likely to be integrated into society than hard-drug users, which enables them to make use of their natural support groups. The third reason, in our view, why most cannabis users can avoid the trajectory of dependency is the fact that its use is not associated with "degenerate addiction" in the view of society or in the popular imagination, unlike the use of heroin, for example. Furthermore, a Canadian study has indicated that "*few (3%) users of illicit drugs, identified in a population survey, reported seeking any kind of help for drug problems.*" [6]

Nevertheless, as in the case of any psychoactive substance, some people opt for or need treatment.

> *It has in fact been observed in groups undergoing treatment - and this is a theory - that there are two groups of people trying to stop using. First, there are people who have mainly used opiates on a regular basis for six or more years. Second, there is the group of users who have been using for two years or less and no longer want to deal with the secondary effects of drugs.* [7]

The decision to seek treatment is determined in particular by the increase in social and personal problems that use of a substance may cause and by the fact that it is often combined with problems of a psychiatric nature.[8] Women systematically make fewer requests for specialized drug and alcohol treatment services; this situation can be explained by the fact that fewer services are available and women are otherwise looked after by traditional psychiatric services.

However, people do not always choose or at least not totally. Family pressures or pressure in the work place and, in some cases, orders made by judges are only some of the factors that lead people to seek treatment. Furthermore, little is known about the trajectories of people who abuse drugs and especially those who seek treatment for the problem. For example, we do not know to what extent the search for treatment is more the result of other earlier problems–family or psychiatric problems–than of the actual use of the substance itself. In the case of drug users who also have problems with the

---

[5] Robert, G. and A, Ogborne (1999) *Best Practices: Substance Abuse Treatment and Rehabilitation*. Ottawa: Canada's Drug Strategy, page 9.

[6] Roberts and Ogborne (1999) *op. cit.* page 59.

[7] Dr. Céline Mercier, *ibid.*

[8] Roberts and Ogborne, *op. cit.* page 60.

law and a career of delinquency, deviant and delinquent behaviour often precedes the start of a trajectory of drug dependency, as we saw in Chapter 6. Demand for treatment in these cases will result at least as much from a desire – or indeed obligation – to put an end to a criminal career as from the detrimental effects of using the substance.

Can people be forced to seek treatment? That was one of the questions raised by the introduction in France of a requirement to seek care in the 1970 Law respecting narcotics, which has now taken the form of a therapeutic injunction,[9] and of drug courts in Canada, as we saw in Chapter 15.

Certain sections of the *Criminal Code* deal with the issue of requiring offenders to seek treatment for problems related to alcohol and drugs. For example, where a court is making a probation order, it has the discretion to require, as a condition to the probation order that:

- The offender, if he or she agrees, participate actively in a treatment program approved by the province, subject to the program director's acceptance; and
- The offender visit a treatment facility for assessment and curative treatment in relation to the consumption by the offender of alcohol or drugs that is recommended pursuant to the program (where a program has been established in a province).[10]

In addition, when a court imposes a conditional sentence, one of the optional conditions of the probation order may be that the offender participate in a treatment program approved by the province.[11]

If a person has not been convicted of a criminal offence, it is unlikely that a court will order treatment for alcohol or drug problems, with some exceptions. For example, persons falling under the authority of provincial mental health legislation may be detained because of mental health problems. Such legislation regulates and limits when a person may be confined against their will.

The reluctance of courts to detain a person for substance abuse problems is illustrated in the Supreme Court of Canada decision in *Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.).*[12] In this case, a young Aboriginal was five months pregnant with her fourth child and was addicted to glue sniffing, a practice which may damage the nervous system of the developing foetus. The Winnipeg Child and Family Services requested assistance from the courts to involuntarily secure the mother in treatment. The case revolved around the issue of the rights of the unborn child, and the Supreme Court of Canada found that neither tort law nor the court's *parens patriae* jurisdiction supported an order for the detention and treatment of a pregnant woman for the purpose of preventing harm to the unborn child.

---

[9] We describe the French system in greater detail in Chapter 20.
[10] *Criminal Code*, paragraphs 732.1(3)(g) and (g.1).
[11] *Criminal Code*, paragraph 742.3(2)(e).
[12] [1997] 3 S.C.R. 925.

In France, the therapeutic injunction has been harshly criticized, especially because it involves enforced treatment. The question is still open despite the guarded assessments that have been made of the results of this practice.[13]

> *The therapeutic injunction system has been in place in France since 1970. A study by a colleague at the* Institut national de santé et de recherche médicale, *in France, showed that many people fell through the cracks because of the therapeutic injunction forcing them to follow a treatment program. These people were never treated, because there were not enough places or follow-up. If we want to set up drug courts in Canada, we shall have to plan effectively and organize consultation mechanisms with the treatment systems to ensure that the required treatment services are available. If we fail to do this, setting up drug courts will be nothing more than a sham, if the people requiring treatment fall through the cracks of the system.*[14]

It is estimated that approximately 10% of the offenders imprisoned in federal institutions are there for offences under the *Controlled Drugs and Substances Act.* Moreover and more importantly, it is estimated that at least 50% of all inmates, whether in provincial prisons or federal detention centres, have dependency problems (drugs and alcohol).[15] Generally, few of these inmates receive any kind of treatment. In the United States, studies indicate that fewer than 10% of inmates receive treatment for dependency problems while they are in prison.[16]

In the case of provincial institutions, this situation can be explained by the short duration of the sentences and by the budget cuts made in correction institutions in the early 1990s. In the case of federal institutions, treatment programs are available but they are still very far from meeting the needs. Furthermore, it may be somewhat ironic to offer treatment programs in institutions where drugs circulate freely and where it is not uncommon for the inmates to have access to cannabis in particular.

Nevertheless, the treatment offered to inmates is an essential component of their reintegration into society given the magnitude of the problems caused by dependency on drugs, especially harder drugs, and alcohol.

One final comment: some of the people who appeared before us observed that in certain cases cannabis maintenance could be used in combination with other forms of withdrawal and treatment for dependency on opiates.[17] To the best of our knowledge, there are no studies on the subject–for good reason! However, we should note, as we did in Chapter 5, that cannabinoid and opioid systems engage in complex interactions,

---

[13] Simmat-Durand, L. (1999), "Les obligations de soins en France", in Faugeron, C., (ed.) *Les drogues en France. Politiques, marchés, usage*, Paris: Georg.

[14] Dr Serge Brochu, Professor in the School of Criminology at the Université de Montréal, testimony before the Senate Special Committee on Illegal Drugs, Senate of Canada, Thirty-Seventh Parliament, First Session, December 10, 2001, Issue 12, page 25.

[15] Brochu, S. (1995) *Drogues et criminalité. Une relation complexe.* Montréal : Université de Montréal.

[16] Lipton, D.S. (1995) *The effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision.* Washington, DC: National Institute of Justice.

[17] Among others at a private meeting with staff of the Vancouver Compassion Club.

and we may be justified in assuming that the consumption of Δ9-THC could cause a dopaminergic response that could reduce opiate withdrawal.

FORMS OF TREATMENT

The 1992 study by Single on the cost of alcohol and drug abuse estimated the cost of specialized treatment for dependency at approximately $290 million. But it would be misleading not to specify that the largest share of treatment dollars is for alcohol: in the case of residential treatment, $180 million was for alcohol and $21 for illicit drugs and in the case of non residential treatment, $82 for alcohol and $8 for drugs.[18]

Most of this money is provided by the provinces and territories. The federal government directly funds rehabilitation for members of the First Nations living on reserves, members of the RCMP and the Armed Forces, inmates in federal institutions and those who have not lived long enough in a province to qualify for the provincial health insurance plan.

This said, the limited resources devoted to treatment of dependency and the growing pressures in terms of the number and diversity of clients, mean that the availability of treatment is limited.

> *Many agencies have received significant cutbacks in recent years. Possibly exacerbating the situation, substance abuse organizations are increasingly being asked to address problem gambling. … Similarly, Bill C-41, which permits court-ordered substance abuse discretion, has an impact on substance abuse treatment at a judge's assessment and treatment resources.* [19]

It is probably not an exaggeration to say that the area of addiction treatment is totally fragmented among the individual practices used by therapists, support and assistance groups, such as addicts anonymous, and therapeutic communities; and among pharmacological, cognitivist and behavioural approaches, psychoanalytic, humanist and systemic approaches; among the proponents of freedom of choice for the user and those who promote enforced treatment. Virtually every possible approach to and form of treatment is available.

Recent reports produced for Health Canada bear witness to this. The Profile of Substance Abuse Treatment programs indicates that in 1998 there were at least 1,200 different treatment programs and approximately 7,200 professional counsellors across the country.[20] Included in these figures are outpatient, day or evening treatment, short-term and long-term reisdential, outreach and crisis treatment programs. The breakdown by province and territory may indicate where priorities are set.

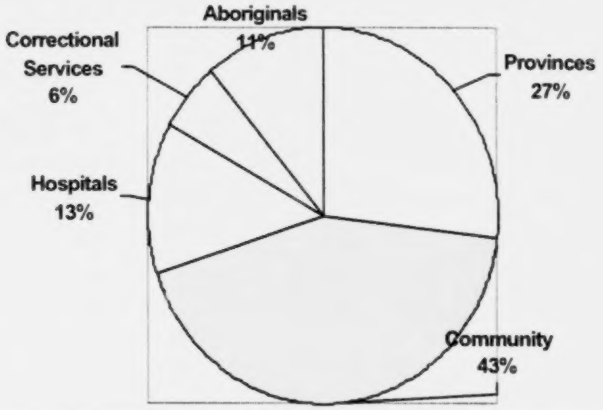
---

[18] Single, E., et. al., *op. cit.*, page 42.

[19] Roberts, G. and A. Ogborne, *op. cit.* page 23.

[20] *Ibid.*, page 6.

Primary affililation of Canadian treatment programs



Substance abuse treatment services offered across Canada[21]

	Outpatient	Day/Even. Treatment	Short-term residential	Long-term residential	Outreach	Crisis	Total
Nfld	13	2	5	0	2	7	29
NS	9	7	7	6	9	4	42
PEI	2	1	1	1	1	2	8
NB	5	3	3	2	3	5	21
Qc	72	52	59	43	48	44	318
Ont	110	55	43	51	61	64	384
Man	12	5	8	10	8	10	53
Sask	24	9	10	5	14	14	76
Alta	41	22	22	13	14	27	139
BC	128	43	39	28	70	77	385
NWT	7	5	3	2	7	7	31
Yukon	2	1	2	0	0	2	7
TOTAL	425	205	202	161	237	263	1493

The primary affiliation of these programs also gives an indication of their orientation. Fully 43% of existing treatment programs are community-based. One of the implications of this fact is that funding is never secure. Overall, the programs may be broken down as follows:[22]

[21] *Ibid.*, page 8.
[22] *Ibid.* page 14.

In terms of the therapeutic approaches used, 31% make use of confrontation and 40% of psychotherapy, but there are very broad differences between individual provinces and territories and even within a given province.[23]

EFFECTIVENESS OF TREATMENT

Once again we should stress the fact that we are not able to discuss specific treatments for cannabis dependency. To our knowledge, no study assessing the effectiveness of these treatments has been completed. Furthermore, of all the treatment and rehabilitation programs that exist in Canada, approximately 14% have been the subject of independent assessments.[24]

Despite the lack of systematic data, it may be possible to state that approaches to treatments for drug dependency are primarily cognitivist and behaviourist in nature. In the cognitivist approaches, an attempt is made primarily to increase the awareness of the fact that a dependency problem exists: objective information and mechanisms of introspection are used to facilitate this awareness. In the behaviourist approaches, the treatments are designed to facilitate changes in lifestyle. It is known, in fact, that drug taking is part of a way of life revolving around a group of acquaintances and involving the frequentation of specific locations. Changing these patterns will help to create a lifestyle in which these drugs are not used.

How effective is this approach? Most of the authors who have examined dependency treatment programs agree in saying that, beyond the humanistic

[23] *Ibid*, page 22.
[24] *Ibid.*, page 15.

dimensions of the treatment, there is a pool of knowledge indicating that they are relatively effective.

More specifically, most of the studies including those conducted in Quebec show that people who seek assistance in rehabilitation centres show improvement.

> [Translation] ... *the people who undertake a rehabilitative approach as part of the services offered in Quebec improve their situation ... this improvement is maintained for a period of six months to one year following the treatment. That is a positive and reassuring result. These results are to the same effect as a very large number of other studies conducted for the most part over the last twenty years.* [25]

In technical terms, the studies do not permit the conclusion that one approach is any more effective than another. The report prepared for Canada's Drug Strategy describes two mega-summaries of assessments of 24 different methods of treatment conducted in the United States and shows that, while the two groups of researchers agree on the effectiveness of a number of forms of treatment, they do not, on the other hand, agree entirely on the order in which they should be placed. We reproduce below the part of the table that shows the most effective approaches.[26]

Classification of effective methods of treatment according to two groups of authors

Holder Index	Method	Method	Finney and Monahan Index
18	Social skills training	Community reinforcement approach	59
17	Self-control training	Social skills training	37
13	Brief motivational training	Marital therapy, behavioural	36
12	Marital therapy, behavioural	Disulfiram, implants	34
6	Community reinforcement approach	Marital therapy, non-behavioural	21
6	Stress management training	Stress management training	12
3	Disulfiram, oral	Aversion therapy, chemical	3
3	Aversion therapy, covert sensitization	Psychotropic medication, anti-depressant	2

The studies do not permit us to conclude that the treatment as such makes a difference and, for some of the authors, the decision to register in a treatment program, no matter what form of treatment, would be more conclusive. The studies do not enable us to determine the ideal duration of treatment, but it would appear that the

[25] Michel Landry, *The impact on addicts of the treatments offered in Quebec.* Brief submitted to the Senate Special Committee on Illegal Drugs, November 2001.

[26] Roberts and Ogborne (1999) *op. cit.* page 9. Note that these treatments apply to all forms of dependency while most assessment studies relate to alcoholism.

effects of treatment level off after 9 to 12 months. In addition, it is difficult to determine the impact of the intensity of the treatment (how many hours per day, days per week).

Finally and most importantly, the positive impacts relate primarily to consumption habits and to the person's general psychological state. However, the treatments apparently have little effect on the reintegration of the individuals into society, which is a particularly important factor in the case of offenders.

As a final point, treatment is more effective and certainly less expensive than incarceration. In Canada, it is estimated that the cost of applying the drug court process is approximately $4,500 per person whereas imprisonment costs an average of $47,000. Even with a success rate of 15%, there can be no doubt that treatment both benefits society and better reflects the real needs of offenders who have problems of dependency.

Speaking more generally, cost-benefit ratio of the treatment has been recog ized:

> *Evidence for the economic benefits of treatment for problems with drugs other than alcohol comes from a large study of drug treatment in the United States (Hubbard et al., 1989). This study involved more than 10,000 drug users and 37 treatment programs that represented three main treatment modalities: methadone maintenance treatment, drug-free outpatient counselling and therapeutic community. ... Two summary measures of these costs were developed: costs to law-abiding citizens, and costs to society. The cost to law-abiding citizens included those associated with crime-related property loss or damage, reduced productivity because of injury or inconvenience occasioned by drug-related crime, and the costs of criminal justice proceedings. Costs to society included cost to victims of drug-related crime, criminal justice costs and "crime/career/productivity costs" incurred when drug users are not involved in earning a legitimate income. The results showed that, in the population studied, both types of costs were lower after treatment than before and that pre-post differences in costs exceeded the costs of treatment.*[27]

[27] Roberts and Ogborne, (1999) *op. cit.*, page 68.

CONCLUSIONS

	Conclusions of Chapter 17
	➢ The expression drug addiction should no longer be used and we should talk instead of substance abuse and dependency. ➢ Between 5% and 10% of regular cannabis users are at risk of developing a dependency. ➢ Physical dependency on cannabis is virtually non-existent. ➢ Psychological dependency is moderate and is certainly lower than that for nicotine or alcohol. ➢ Most regular users of cannabis are able to diverge from a trajectory of dependency without requiring treatment. ➢ There are many forms of treatment but nothing is known about the effectiveness of the different forms of treatment for cannabis dependency specifically. ➢ As a rule, treatment is more effective and less costly than a prison sentence. ➢ Studies of the treatment programs should be conducted, including treatments programs for people with cannabis dependency. ➢ Studies should be conducted of the interaction between the cannabinoid system and the opioid system.

CHAPTER 18

OBSERVATIONS ON PRACTICES

In previous chapters, we described public action by dividing it up into the major sectors of involvement. Before closing the third part of this report, we would like to make some general observations that cut across the individual areas we have examined. The first concerns difficulties in harmonizing the various levels and sectors of involvement; the second, the difficulty in co-ordinating their various approaches; and the third, the costs of drugs and public policy.

DIFFICULTIES IN HARMONIZING THE PLAYERS

Without reopening the debate on the division of power and responsibilities among the various levels of government, we consider it obvious that any public policy on illegal drugs, and cannabis in particular, applies to all three levels. Drugs affect education and health (primarily provincial jurisdictions), justice (a responsibility shared between the federal and provincial governments), public well-being and public safety (which involve all three levels), international relations (a federal responsibility), and even culture, science and research (essentially provincial). Thus we are attempting to make our way through a field that is at least tangled, if not chaotic.

Co-ordinating mechanisms do exist. On the most formal level, the federal-provincial-territorial Deputy Ministers of Health Working Group is responsible for co-ordinating the drug strategy. But we know almost nothing about their discussions, which are held *in camera*, or any concrete results.

The Canadian Centre on Substance Abuse (CCSA) is another coordinating mechanism, but only a few provinces have equivalent partners (Ontario, Manitoba, Alberta and Quebec, with some reservations). And the Centre has neither the budget, the infrastructure nor even the legitimacy, which it would derive from a clear mandate, needed to initiate a genuine national dialogue on the issue.

Yet another coordinating mechanism is the Health, Education and Enforcement in Partnership (HEP) network.. Established in 1994 by the CCSA, the HEP network is rooted in the balanced approach of Canada's Drug Strategy: seeking an equilibrium between supply reduction and demand reduction. HEP unites key players in the health

and enforcement fields in this common focus and includes other partners, notably in education, social services, correctional services and justice. On a national level, its Steering Committee is composed of representatives of the Addictions Foundation of Manitoba, the Canadian Association of Chiefs of Police (co-chair), the Canadian Centre on Substance Abuse (co-chair), the Correctional Service of Canada, the Canadian Federation of Municipalities, Health Canada, Justice Canada, the National Centre for Crime Prevention, the RCMP and the Solicitor-General. How many readers of this report, even among those actively engaged in the drug field, are aware of this partnership, its achievements, actions and benefits?

In Chapter 14, we examined the disparate response of police services across the country to the application of the law–between regions, provinces and territories and, within provinces and territories, between cities. In Chapter 15, we noted that all the evidence suggests that the same holds true of the judicial response. Chapters 16 and 17, on preventive practices and treatment respectively, described the same unequal or fragmented approaches.

In a federation like Canada, it is to be expected that differences in practice and direction will co-exist. How the issue of cannabis is seen and dealt with will not be the same in the greater Vancouver area, with its explosion of growers, as in Quebec, with its criminal motorcycle gangs, or as in Prince Edward Island, which has almost no problems with production or even with abuse of cannabis. The difficulties experienced in the downtown cores of major cities are not those of smaller urban centres. And First Nations people have their own quite specific problems.

Nevertheless, among other effects, the difficulties in harmonizing the action of different levels of government mean in concrete terms that:

- Results of a successful experiment in prevention conducted in one area of the country will not reach the players in another part.
- Therapeutic practices that have been proven to be ineffective will continue to be used elsewhere because the information is not circulated.
- There is no national knowledge infrastructure on use and use trends; for example, the few studies that have been conducted in school environments are not comparable and are not (all contemporary?).
- Some cities have adopted policies based on the idea of a drug-free society while others are focused on harm reduction.

Notably absent in the development of public policy is the civil society, especially community-based organizations (rehabilitation organizations, for example) and also user self-help support groups (including compassion clubs and groups of users of cannabis for therapeutic purposes).

The hyperbola that would make drugs into a bigger social issue than they actually are aside, it remains that the use of psychoactive substances, legal or illegal, and the resulting problems of dependency that may follow, concern every citizen, every level of

government, throughout the country. This is a *national issue.* That, unquestionably, the future and quality of our health system, the protection of our national interests and security, the quality of education and the protection of the environment are even more important issues does not mean that drugs are not a *national priority.* Or should be, at least. Quite apart from its social and economic consequences, which will be discussed later, the drug issue should be a priority because it concerns the education of children and adolescents, affects the quality and safety of living environments, and causes suffering and wasted lives. Granted that this is not so much the case for cannabis, whose social and economic effects cannot be compared to those of alcohol, but, while agreeing that cannabis calls for a different approach, we cannot isolate it from other psychoactive substances. We need to develop a comprehensive national policy on drugs and addiction, within which cannabis would have a place.

Better harmonization among levels of government and with civil society would allow us to lay the foundations of a shared understanding of the issues presented by psychoactive substances, and above all to develop a common set of indicators for assessing the effectiveness of policies and actions.

INCONGRUITIES OF APPROACH

Some myths are long-lived. Although not supported by the empirical research we have examined, images of cannabis leading to use of hard drugs, damaging brain functions permanently, or causing academic failure, to name but these few, continue to abound.

We are well aware that there is no international consensus among researchers on these issues. But we are equally aware that it is difficult to alter preconceptions. Last year, at an international scientific conference in Europe, whose results we have already cited, some participants concluded that, although a consensus was emerging in the research community, its existence was irrelevant because all the countries represented were signatories of international conventions on drugs. One always finds ways to circumvent reality when it does not fit ideology.

Let there not be finger-pointing. Those who most frequently hold these beliefs about cannabis are also those who are confronted daily with the negative effects of drug abuse: crime and violence for the police officer on the beat; human misery for those in therapeutic practice. Their view of drugs, of cannabis in particular, is naturally coloured by their experience, which puts them in situations of contact with abuse, distress, violence and death. But those users who require treatment are no more representative of the cannabis user population than are the street kids and petty offenders the police see constantly.

Clearly, what is required is a bridge, an intermediary between the worlds of research and the front lines, between decision-makers and field workers and between

them all and civil society. While the research is not perfect, while we deplore the lack of a truly national system of information, the information is, nevertheless, there in quantity, as we have had occasion to observe in the course of our proceedings. But it needs wide circulation, and above all it needs to be the subject of public debate and discussion. The CCSA could disseminate this information and promote discussion, were it given the resources - a role it has never had the means to play.

The researchers themselves must bear some of the responsibility for the situation. They tend not to care whether their work reaches those in positions of power or whether it is distributed in political forums or in the field. Some are still shackled to the idea of "academic freedom," thinking that their involvement in the worlds of decision-making and practice will contaminate the objectivity of their research. It is thus not surprising that knowledge of the players on the ground is limited to what their experience provides; nor are the institutions to which they belong necessarily equipped to systematize and contextualize such knowledge either.

We have observed a serious gulf between the positions taken by the research community and those taken by front-line workers, including the police and the therapeutic community. It would be too easy to reduce the position of the practitioners to "corporate" interests. There is a need for basic discussion and exchange, which is not happening among the various players; and too often the experience-based knowledge derived from practice has no legitimacy in the eyes of the scientific community, though this is the knowledge that attracts the attention of the decision-makers, the media and the general public.

In practice, glaring contradictions arise between the discourse and the approach of the two sides. While young people hear about the potential therapeutic value of cannabis and about decriminalization, they see police operations in the schools and listen to classroom lectures on its dangers. While the primary targets of police action are supposed to be the traffickers, young people read that thousands of people are arrested every year for simple possession of marijuana. While images of junkies destroyed by heroin are flashed in the media, young people also hear that it is available by prescription. And drug users continued to be picked up by the police as they leave needle-exchange clinics. Caught between these contradictory words and actions, how should they know what to think?

These incongruities are exacerbated by the imbalance in power and resources. Non-profit groups that provide cannabis for therapeutic purposes talked about this at length: their credibility with law-enforcement agencies is often hard earned, built over time, with a few individual members of the police. They are well aware that their status is precarious and that they might have to "bail out" at any moment. Public health agencies that attempt to foster discussion and introduce harm-reduction practices are equally aware that they are operating at the outer limits of the law and that their actions are not universally supported. Researchers who wish to study the therapeutic applications of cannabis are restricted by the present system of prohibition.

In the case of alcohol, a decision-making structure exists to give a relatively equal voice to the various players involved. It includes the agencies that regulate production, distribution and sale, the public health organizations that work to reduce at-risk behaviours and clarify the determinants of abuse, the justice system that intervenes to prevent smuggling and arrest those irresponsible people who drive while impaired. The co-operation and dialogue among these players is close and constant, and there are even formal channels for co-operation and dialogue with the distilling and brewing industries. The result, by and large, is uniform practices and views, although this is not to imply that all problems have been solved. But in the field of illegal drugs, there is nothing like this. Dialogue where certain words cannot be spoken or ideas expressed, where certain decisions can never be made and resources are so unequally shared among the players, is merely empty an exercise meant to give the illusion that something is being achieved.

SIGNIFICANT ECONOMIC AND SOCIAL COSTS [1]

In 1996, the Canadian Centre on Substance Abuse published the first study on costs related to alcohol, tobacco and drug abuse in Canada.[2] Estimating costs raises difficult technical questions: what should be included, and how should each element be measured? The very analysis of public drug policies is predicated on the assumption that a number of the associated social costs can be reduced, if not eliminated altogether. These costs are of two major types: those associated with public policy, primarily the cost of prevention and suppression, as well as those of administering the policy; and the costs that would be avoided if the problems stemming from substance abuse were eliminated–the so-called "counter-factual" scenario. In these, the effects of drugs are treated as social costs, that is, as a diminution of the collective well-being. This amounts to saying that all the costs of drug abuse are social costs, or what economists call "externalities" or "spill-overs" – secondary rather than primary consequences.

Moral considerations aside for the moment, there is no doubt that use of drugs can have certain benefits–albeit short-term and to some extent non-rational ones–for the users, and even for those around them. Hyperactive individuals calmed by cannabis, those whose productivity is enhanced by the use of cannabis or whose mental or physical suffering is attenuated, or those who smoke a joint in the evening to relax or

---

[1] For an excellent discussion of these analyses and for some of the best studies on the subject, see the report prepared for this committee by Jackson, A.Y. (2002) *Costs of drugs and drug policy*. Ottawa, Library of Parliament, report produced for the Senate Special Committee on Illegal Drugs, available online at www.parl.gc.ca/illegal-drugs.asp.

[2] Single, E. *et al*, (2002) *The Costs of Substance Abuse in Canada: a cost estimation study*. Ottawa, Canadian Centre on Substance Abuse.

help them sleep and are in better shape to work the next day as a result, are just a few examples. And they are not unusual cases.

From another point of view, the underground drug economy, not trafficking on a major scale, but small-scale neighbourhood supply, whether in poorer or wealthier areas, generates certain economic benefits and even some capacity to integrate socially. Entire families are supported by small-scale dealing. Houses, cars, travel and luxury clothing are financed by drug sales. The amount of the wealth they generate can be illustrated by the example of British Columbia. In this province alone the cannabis-based economy is estimated to be worth $6 billion annually. It can be assumed that a major part of this revenue, let us say half, goes to people who are otherwise well integrated socially and are not part of the criminal culture.

The analysis of social costs based only on externalities does not take into account the drug economy.

Ultimately it rests on another hypothesis, equally difficult to defend, which is that the money saved if the social costs of drug use were reduced could be invested elsewhere; in economic theory these costs are known as "opportunity costs". However, money saved on enforcement of cannabis laws would probably be redistributed within the police organization; other social costs might also arise from the substitution of other substances.

Having set out these caveats, Single's study produced the following table[5].

Total cost of alcohol, tobacco and illegal drugs in Canada, 1992

	Alcohol	Tobacco	Drugs	Total
1. Direct health care costs: total	**$1,300.6**	**$2,675.5**	**$88.0**	**$4,064.1**
1.1 morbidity-general care hospitals	666.0	1,752.9	34.0	2,452.9
-psychiatric hospitals	29.0	--	4.3	33.3
1.2 co-morbidity	72.0	--	4.7	76.7
1.3 ambulance services	21.8	57.2	1.1	80.1
1.4 home care	180.9	--	20.9	201.8
1.5 outpatient treatment	82.1	--	7.9	90.0
1.6 ambulatory care: doctors' fees	127.4	339.6	8.0	475.0
1.7 prescription medications	95.5	457.3	5.8	558.5
1.8 other health care costs	26.0	68.4	1.3	95.8
2. Direct losses in the workplace	**14.2**	**0.4**	**5.5**	**20.1**
2.1 EAP and health promotion programs	14.2	0.4	3.5	18.1
2.2 drug testing in the workplace	N/A	--	2.0	2.0
3. Direct administrative costs for transfer payments	**52.3**	**--**	**1.5**	**53.8**
3.1 social assistance benefits and other programs	3.6	--	N/A	3.6

[5] Single, E. *et al* (1996) *op. cit.*

	Alcohol	Tobacco	Drugs	Total
3.2 workers' compensation	48.7	--	1.5	50.2
3.3 other administrative costs	N/A	N/A	N/A	N/A
4. Direct costs for prevention and research	**141.4**	**48.0**	**41.9**	**231.1**
4.1 research	21.6	34.6	5.0	61.1
4.2 prevention programs	118.9	13.4	36.7	168.9
4.3 training costs for doctors and nurses	0.9	N/A	0.2	1.1
4.4 costs for behavioural modification	N/A	N/A	N/A	N/A
5. Direct costs of law enforcement	**1,359.1**	**--**	**400.3**	**1,759.4**
5.1 police	665.4	N/A	208.3	873.7
5.2 courts	304.4	N/A	59.2	363.6
5.3 correctional services including probation	389.3	N/A	123.8	513.1
5.4 customs and excise	N/A	N/A	9.0	9.0
6. Other direct costs	**518.0**	**17.1**	**10.7**	**545.8**
6.1 damages due to fire	35.2	17.1	N/A	52.3
6.2 damages due to traffic accidents	482.8	--	10.7	493.5
7. Indirect costs: loss of productivity	**4,136.5**	**6,818.8**	**823.1**	**11,778.4**
7.1 loss of productivity due to illness	1,397.7	84.5	275.7	1,757.9
7.2 loss of productivity due to death	2,738.8	6,734.3	547.4	10,020.5
7.3 loss of productivity due to crime	--	--	N/A	N/A
Total	**7,522.1**	**9,559.8**	**1,371.0**	**18,452.9**
Total % of GDP	*1.09%*	*1.39%*	*0.20%*	*2.67%*
Total per capita	*$265*	*$336*	*$48*	*$649*
Total % of all costs related to substances	*40.8%*	*51.8%*	*7.4%*	*100.0%*

An examination of these data indicates:

- In 1992, the costs associated with all illegal drugs were $1.4 billion, compared with $7.5 billion in the case of alcohol and $9.6 billion in the case of tobacco.
- Expressed as a percentage of the gross domestic product, the total costs for all substances was 2.67%. Of this, 0.2% was for illegal drugs, 1.09% for alcohol and 1.39% for tobacco.
- The principal costs of illegal drugs are externalities, that is, loss of productivity ($823 million), health care ($88 million), losses in the workplace ($5.5 million), for a total of about 67% of all costs related to illegal drugs.
- The cost of public policies, or opportunity costs, represent about 33% of what.

- The cost of enforcing the law represents about 29.2% of all costs, or about 88% of all policy costs. The balance goes to prevention, research and administration.

Previous studies conducted in British Columbia (1991), Ontario (1988) and Quebec (1988), using different methodologies, established costs of $388 millions, $1.2 billion and $2 billion respectively, for a total cost of $3.5 billion for these three provinces alone.[4] These figures demonstrate the extent to which such estimates can vary, according to the methodology selected and the availability of data.

Nevertheless, with the CCSA study taken as the standard, two comments must be made. First, loss of productivity–the major cost–is measured in mortality ($547 million) and morbidity ($275 million). Except in the case of traffic fatalities, cannabis is not a cause of death and involves none of this type of social cost. Morbidity corresponds to losses attributed to problems caused by drug use as measured by the difference between the average annual income of users and of the population in general. Here, two further observations about cannabis should be noted. A large proportion of cannabis users are young people who are not yet part of the workforce; and cannabis use involves none of the addiction and attendant problems that follow from heroin or cocaine use. It is, therefore, the costs that can be attributed to cannabis in this regard are likely minimal. If one accepts the methodology of the authors, **cannabis in itself entails few externalities**, which are the main measures of the social cost of illegal drugs.

However, it should also be noted that the study did not calculate the costs of substance-related crime. Alcohol is well known for its frequent association with crimes of violence (at least 30% of all cases), as well as with impaired driving , which results in major social and economic losses. Crime related to illegal drugs is of several types: organized crime, of course; crimes against property committed in order to pay for drugs, true mainly in the case of heroin and cocaine; and crimes of violence committed under the influence of drugs. With the exception of organized crime and driving under the influence, cannabis involves few of the factors that generate criminal behaviour.

Secondly, according to Single's study, the main cost of illegal drugs, after loss of productivity, is the cost of law enforcement, which the study estimates at approximately $400 million. In Chapters 14 and 15, we noted that police and court costs are certainly much higher than this figure, and probably total between $1 billion and $1.5 billion. As Single *et al* state, these are costs that "are incurred as a conscious decision by policy makers, as opposed to those costs imposed on the treatment system and on industry as a result of substance-related morbidity and mortality."[5] The proportion of these costs attributable to cannabis is, obviously, impossible to determine for certain. But, insofar as 77% of all drug-related offences involve cannabis, and of these 50% involve simple possession, and given that about 60% of incidents result in a charge, of which some

[4] Single, E. *et al*, *op.cit.*, page 15.

[5] *Ibid.*, page 57.

10% to 15% of cases the accused receives a prison sentence, it is clear that a considerable proportion of the drug-related activity addressed by the penal justice system is concerned with cannabis. While admitting this to be a very rough estimate, we suggest that about 30% of the activity of the justice system is tied up with cannabis. On the basis of our estimates and the lowest cost of law enforcement, or $1 billion, it costs about $300 million annually to enforce the cannabis laws.

In effect, the main social costs of cannabis are a result of public policy choices, primarily its continued criminalization, while the consequences of its use represent a small fraction of the social costs attributable to the use of illegal drugs.

Next to this, the costs of prevention and research pale into insignificance. Single estimates them at approximately $42 million in 1992, at the height of Canada's Drug Strategy – a strategy that ceased to be funded after 1997. Far from increasing since then, it is probable that expenditures for prevention and research have decreased as a proportion of the total social cost of drugs.

At several points in this report, we have spoken about the Canadian Centre on Substance Abuse, pointing out both its lack of visibility and legitimacy and its lack of resources the two being related. The economic and social costs of illegal drugs alone on the order of $1.5 billion (which in light of our estimate of the costs of suppression alone is certainly the floor), the annual budget of the CCSA represents a mere 0.1% of them! Considering that the CCSA's mandate is to facilitate everything we have just been discussing, and to serve as a clearing-house for information, practical experience and best practices, there is good reason to wonder whether successive governments have not failed to put their money where their mouth is in their approach to the drug issue. The social costs of alcohol, a substance that also falls within the CCSA's purview, have not even been included in this calculation, though they are at least seven times greater than those of illegal drugs! This is why it is imperative to raise the proportion of funding to the CCSA from 0.1% to 1%–a drop in the bucket for the federal government that would produce inestimable benefits.

CONCLUSIONS

Conclusions of Chapter 18	
Harmonization	➢ **The lack of any real national platform for discussion and debate on illegal drugs prevents the development of clear objectives and measurement indicators.** ➢ **The absence of a national platform makes exchange of information and best practices impossible.** ➢ **Practices and approaches vary considerably between and within provinces and territories.**

Co-ordination of approaches	➢ **The conflicting approaches of the various players in the field are a source of confusion.** ➢ **The resources and powers for enforcement are greatly out of balance compared with those of the health and education fields and the civil society.**
Costs of cannabis	➢ **The costs of all illegal drugs had risen to close to $1.4 billion in 1992.** ➢ **Of the total costs of illegal drugs at that time, externalities (social costs) represented 67% and public policy costs 33%.** ➢ **We believe both the social costs of illegal drugs and the public policy costs to be underestimated.** ➢ **We estimate the cost of enforcing the drug laws to be closer to $1-1.5 billion per annum.** ➢ **The principal public policy cost relative to cannabis is law enforcement and the justice system; we estimate this to represent a total of $300-$500 million per annum.** ➢ **The costs of externalities attributable to cannabis are probably minimal (no deaths, few hospitalizations, and very little loss of productivity).** ➢ **The costs of public policy on cannabis are disproportionately high given the drug's social and health consequences.**
Under-funding of the CCSA	➢ **The Canadian Centre on Substance Abuse is seriously under-funded; its annual budget amounts to barely 0.1% of the social costs of illegal drugs alone (alcohol not included). Its budget should be increased to at least 1%; that is, approximately $15 million per annum.**

Sénat Senate

CANADA

LE CANNABIS :

POSITIONS POUR UN RÉGIME DE POLITIQUE PUBLIQUE POUR LE CANADA

RAPPORT DU COMITÉ SPÉCIAL DU SÉNAT SUR LES DROGUES ILLICITES

VOLUME II : PARTIE III

PRÉSIDENT

PIERRE CLAUDE NOLIN

VICE-PRÉSIDENT

COLIN KENNY

SEPTEMBRE 2002

TABLE DES MATIÈRES

GLOSSAIRE DES PRINCIPAUX TERMES

INTRODUCTION 1

PREMIÈRE PARTIE – ORIENTATIONS GÉNÉRALES 5

CHAPITRE 1 – NOTRE MANDAT 7
LIBELLÉ 7
ORIGINES 9
NOTRE COMPRÉHENSION 11

CHAPITRE 2 – NOS TRAVAUX 13
DEUX PRINCIPES DE TRAVAIL 14
L'ÉTAT DES CONNAISSANCES 15
Le programme de recherche 19
Audiences de témoins experts 20
Le défi de la synthèse 22
TENIR COMPTE DES OPINIONS 23
INTERPRÉTER À LA LUMIÈRE DE PRINCIPES 24

CHAPITRE 3 – NOS PRINCIPES DIRECTEURS 25
L'ÉTHIQUE, OU LE PRINCIPE DE L'AUTONOMIE RÉCIPROQUE 28
LA GOUVERNANCE : MAXIMISER L'ACTION DES INDIVIDUS 32
La gouvernance de la collectivité 34
La gouvernance de soi 36
Le rôle de la gouvernance 37
LE DROIT PÉNAL OU LES LIMITES DE L'INTERDICTION 38
Nécessité de la distinction 39
Critères de distinction 41
Application aux drogues illicites 45
LA SCIENCE OU LA CONNAISSANCE APPROCHÉE 46
CONCLUSIONS 51

CHAPITRE 4 – UN CONTEXTE EN MOUVANCE 53
MUTATIONS DU CONTEXTE INTERNATIONAL 53
Globalisation et intégration 53
Errances d'un discours sécuritaire 57
Des politiques antidrogues aux politiques sur les drogues 59
MUTATIONS AU CANADA 61
L'activisme judiciaire 61
Une stratégie nationale de prévention du crime 62
La lutte au crime organisé 62
UN DÉBAT DE SOCIÉTÉ 63

PARTIE II – LE CANNABIS : EFFETS, USAGES, ATTITUDES 65

CHAPITRE 5 – LE CANNABIS : DE LA PLANTE AU JOINT 67
UNE PLANTE, DIVERSES DROGUES 68
ROUTES DU CANNABIS 72
PROPRIÉTÉS DU CANNABIS 79
Concentration en Δ^9THC 80
PHARMACOCINÉTIQUE 86
CONCLUSIONS 90

CHAPITRE 6 – USAGERS ET USAGES : FORMES, PRATIQUES, CONTEXTES 93
TENDANCES D'USAGE 94
Consommation en population générale 95
Consommation chez les jeunes 99
Tendances d'usage dans d'autres pays 105
Éléments de synthèse 114
FORMES ET MODES D'USAGE 116
Le cannabis dans l'histoire 117
Trajectoires d'usages 119
Facteurs reliés à l'usage 125
Éléments de synthèse 131
UNE ESCALADE VERS D'AUTRES DROGUES ? 132
CANNABIS, VIOLENCE ET CRIMINALITÉ 134
CONCLUSIONS 136

CHAPITRE 7 – LE CANNABIS : EFFETS ET CONSEQUENCES 139
EFFETS ET CONSÉQUENCES DU CANNABIS : CE QU'ON NOUS A DIT 142
EFFETS AIGUS DU CANNABIS 148
CONSÉQUENCES DE LA CONSOMMATION CHRONIQUE 152
Conséquences physiologiques de l'usage chronique 153
Conséquences cognitives et psychologiques 158
Conséquences comportementales et sociales 162
TOLÉRANCE ET DÉPENDANCE 163
Dépendance au cannabis 164
Sévérité de la dépendance 171
La tolérance 174
ÉLÉMENTS DE SYNTHÈSE 175
CONCLUSIONS 176

CHAPITRE 8 – CONDUITE SOUS L'EFFET DU CANNABIS **179**
MODES DE DÉPISTAGE 182
DONNÉES ÉPIDÉMIOLOGIQUES 187
Études hors contexte accidentel 188
Études en contexte accidentel 189
Enquêtes épidémiologiques auprès des jeunes 192
Évaluation du risque 192
ÉTUDES EXPÉRIMENTALES 195
Activités hors conduite 195
En activité de conduite 197
CONCLUSIONS 201

CHAPITRE 9 – APPLICATIONS THÉRAPEUTIQUES DU CANNABIS **203**
ASPECTS HISTORIQUES 208
CONNAISSANCES CONTEMPORAINES 210
Utilisations thérapeutiques 210
Le cannabis comme médicament ? 213
PRATIQUES THÉRAPEUTIQUES ACTUELLES 216
CONCLUSIONS 219

CHAPITRE 10 – OPINIONS ET ATTITUDES DES CANADIENS **221**
LES MÉDIAS 222
ENQUÊTES ET SONDAGES 227
ATTITUDES ET OPINIONS EXPRIMÉES AU COMITÉ 234
CONCLUSIONS 237

PARTIE III – POLITIQUES ET PRATIQUES AU CANADA **239**

CHAPITRE 11 – UNE STRATÉGIE CANADIENNE ANTIDROGUE ? **241**
PHASE I – ÉLABORATION ET MISE EN PLACE **242**
Création du Centre canadien de lutte contre l'alcoolisme et les toxicomanies **248**
Création du Secrétariat de la Stratégie canadienne antidrogue **250**
PHASE II – RENOUVELLEMENT **252**
PHASE III – LE RENOUVELLEMENT SANS FINANCEMENT PRÉCIS **255**
LA STRATÉGIE CANADIENNE ANTIDROGUE – UNE RÉUSSITE ? **257**
CONCLUSIONS **259**

CHAPITRE 12 – LE CONTEXTE LÉGISLATIF NATIONAL **261**
1908-1960 : L'HYSTÉRIE **264**
La Loi sur l'opium de 1908 **269**
Loi sur l'opium et les narcotiques de 1911 **269**
Les amendements à la Loi sur l'opium et les narcotiques (1920-1938) **272**
Les modifications à la Loi sur l'opium et les narcotiques en 1954 **281**
Le rapport du Sénat de 1955 **282**
DE 1960 À LA COMMISSION LEDAIN : À LA RECHERCHE DES RAISONS PERDUES **286**
La Loi sur les stupéfiants (1961) **286**
La Loi sur les aliments et drogues et les barbituriques (1961) **288**
La Commission Le Dain (1969-1973) **291**
Le projet de loi S-19 et le cannabis **302**

APRÈS LEDAIN : LA FUITE EN AVANT 303
La Loi réglementant certaines drogues et autres substances 305
CONCLUSIONS 315

CHAPITR E 13 – RÉGLEMENTER L'UTILISATION DU CANNBIS À DES FINS THÉRAPEUTIQUES 317
CADRE ENTOURANT LA RÉCENTE RÉGLEMENTATION 318
Article 56 – Loi réglementant certaines drogues et autres substances 318
Contestations fondées sur la Charte – utilisation de la marijuana à des fins thérapeutiques 320
Réaction du gouvernement 322
RÉGLEMENTATION SUR L'ACCÈS À LA MARIJUANA À DES FINS MÉDICALES 323
Autoristion de posséder 324
Licences de production 328
Autres dispositions 329
ACCÈS HUMANITAIRE ? 329
Admissibilité 330
Accès au cannabis 335
Produits 338
Coûts 338
POURSUIVRE LA RECHERCHE 340
Recherche scientifique 340
Marijuana propre à la recherche 343
CONCLUSIONS 344

CHAPITRE 14 – PRATIQUES POLICIÈRES 347
ORGANISMES D'EXÉCUTION DE LA LOI 347
GRC 347
L'Agence des douanes et du revenu du Canada 350
Polices municipales et provinciales 352
COÛTS 353
POUVOIRS POLICIERS 358
Fouilles perquisitions et saisies 360
La provocation policière et les activités illégales 374
Conclusion 379
STATISTIQUES 380
Incidents relatés 380
Accusations 383
Inquiétudes 386
La Loi sur les douanes – amendes 389
SAISIES 390
CONCLUSIONS 392

CHAPITRE 15 – LE SYSTÈME DE JUSTICE PÉNALE 393
POURSUITES 393
TRIBUNAUX 394
Les tribunaux de traitement de la toxicomanie 395
DÉCISION ET DÉTERMINATION DE LA SANCTION 399
SERVICE CORRECTIONNEL 402
CASIER JUDICIAIRE 406
CONTESTATIONS JUDICIAIRES 409
CONCLUSIONS 415

CHAPITRE 16 – PRATIQUES PRÉVENTIVES 417
DES ACTIONS QUI NE SONT PAS À LA HAUTEUR DES DISCOURS 421
On ne fait pas suffisamment de prévention 422
La prévention est insuffisamment ciblée 424
On ne fait pas suffisamment l'évaluation des mesures de prévention 426
Les messages sociaux contredisent les messages de prévention 427
Il existe une connaissance dont il faut s'inspirer 428
PRÉVENIR : QUOI ? COMMENT ? 429
RÉDUCTION DES RISQUES, RÉDUCTION DES MÉFAITS 441
CONCLUSIONS 443

CHAPITRE 17 – PRATIQUES DE SOINS 445
DÉPENDANCES AU CANNABIS 445
FORMES DE TRAITEMENT 451
L'EFFICACITÉ DES TRAITEMENTS 453
CONCLUSIONS 456

CHAPITRE 18 – OBSERVATIONS SUR LES PRATIQUES 457
DES DIFFICULTÉS D'ARTICULATION ENTRE LES ACTEURS 457
UN ARRIMAGE DIFFICILE ENTRE LES APPROCHES 459
DES COÛTS ÉCONOMIQUES ET SOCIAUX IMPORTANTS 462
CONCLUSIONS 467

PARTIE IV – OPTIONS DE POLITIQUE PUBLIQUE 469

CHAPITRE 19 – LE CONTEXTE JURIDIQUE INTERNATIONAL 471
ÉLÉMENTS DE GÉNÉALOGIE 472
La Conférence de Shanghai (1909) 475
La Convention internationale de l'opium de 1912 (La Haye) 477
Les Conventions de l'opium de Genève (1925) 479
La Convention de Genève pour limiter la fabrication et réglementer la distribution des stupéfiants (1931) / Accord de Bangkok sur la consommation d'opium (1931) 480
La Convention pour la répression du trafic illicite des drogues nuisibles (Genève, 1936) 482
La Deuxième Guerre mondiale 482
Le Protocole de LakeSuccess (1946) 483
Le Protocole de Paris (1948) 483
Le Protocole de l'opium de New York (1953) 484
LES TROIS CONVENTIONS ACTUELLES 485
La Convention unique sur les stupéfiants de 1961 485
Convention sur les substances psychotropes 490
Protocole portant amendement à la Convention unique sur les stupéfiants de 1961 496
Convention contre le trafic illicite de stupéfiants et de substances psychotropes 498
UNE MARGE DE MANŒUVRE ? 501
CONCLUSIONS 504

CHAPITRE 20 – POLITIQUES PUBLIQUES DANS D'AUTRES PAYS **507**
FRANCE 508
Des logiques distinctives 508
Une politique publique intégrée 510
Cadre législatif 513
Quelques rapports clés 516
Statistiques sur l'usage et la répression 520
Coûts 523
PAYS-BAS 524
Le pragmatisme néerlandais ? 525
Des rapports d'experts fondateurs 527
La législation 533
Le régime des coffee shops 536
Données sur l'usage 538
ROYAUME-UNI 542
Stratégie décennale de lutte contre la toxicomanie 542
Cadre législatif 543
Autres lois pertinentes au domaine de la toxicomanie 546
Débats au RU 547
Études et rapports récents 548
Administration 556
Coûts 556
Statistiques 558
LA SUÈDE 560
Stratégie nationale 562
Cadre législatif 566
Le débat en Suède 568
Rapports récents 569
Coûts 571
Administration 572
Statistiques 572
LA SUISSE 575
Une politique de réduction des risques 575
Évolution du régime juridique 583
Un projet de dépénalisation du cannabis 585
Administration de la politique suisse en matière de drogue 587
Statistiques sur l'usage de stupéfiants et les infractions à la LStup 589
L'AUSTRALIE 592
Stratégie nationale sur les drogues 592
Le cadre législatif 597
Décriminalisation du cannabis 601
Administration 603
Statistiques 605
LES ÉTATS-UNIS 607
Le cadre législatif de l'administration fédérale et des États 607
La législation actuelle et son application 610
Buts et objectifs de la politique fédérale de lutte contre les stupéfiants 619
Administration de la politique 622
Sujets d'actualité et débats 624
Statistiques 626

CHAPITRE 21 – OPTIONS DE POLITIQUE PUBLIQUE **631**
L'INEFFICACITÉ DES POLITIQUES PÉNALES 633

Des impacts sur la consommation ? 634
Des impacts sur l'offre ? 640
Conclusion 640
ÉCONOMIE GÉNÉRALE D'UNE POLITIQUE PUBLIQUE SUR LE CANNABIS 641
COMPOSANTES D'UNE POLITIQUE PUBLIQUE 644
Un centre de responsabilité fort 644
Interconnexion 645
Élaboration en commun d'objectifs partagés 645
Des outils de connaissance 645
OPTIONS LÉGISLATIVES 646
Clarifications terminologiques 646
Critères pour une politique juridique sur le cannabis 654

CONCLUSIONS ET RECOMMANDATIONS 659

IL Y A TRENTE ANS, LE DAIN 659
L'INEFFICACITÉ DES PRATIQUES ACTUELLES 661
UNE POLITIQUE PUBLIQUE BASÉE SUR DES PRINCIPES DIRECTEURS 663
UNE STRATÉGIE FÉDÉRALE CLAIRE ET COHÉRENTE 664
UNE STRATÉGIE NATIONALE SOUTENUE PAR DES MOYENS ET DES OUTILS 665
UNE POLITIQUE DE SANTÉ PUBLIQUE 667
UNE APPROCHE RÉGLEMENTAIRE SUR LE CANNABIS 670
UNE APPROCHE DE COMPASSION POUR LES USAGES THÉRAPEUTIQUES 671
DISPOSITIONS SUR LA CONDUITE SOUS L'INFLUENCE DU CANNABIS 672
POURSUIVRE LA RECHERCHE 673
POSITIONNEMENT INTERNATIONAL DU CANADA 674

PROPOSITIONS DE MISE EN ŒUVRE DE LA RÉGLEMENTATION DU CANNABIS AUX FINS THÉRAPEUTIQUES ET RÉCRÉATIONNELLES 676

BIBLIOGRAPHIE 681

GLOSSAIRE DES PRINCIPAUX TERMES

Abus
Terme vague qui reçoit une grande variété de significations, selon les contextes sociaux, médicaux, et juridiques. Selon certains, tout usage de drogues illicites est un abus : ainsi, les conventions internationales considèrent l'usage de toute substance prohibée pour des fins autres que médicales ou scientifiques comme un abus. Le Manuel diagnostic de l'Association américaine de psychiatrie définit l'abus comme un mode d'utilisation inadéquat d'une substance conduisant à une altération du fonctionnement ou à une souffrance cliniquement significative, et suggère 4 critères (voir le chapitre 7 du rapport). Nous lui préférons le concept d'usage excessif (ou usage nocif).

Accoutumance *(de l'anglais addiction)*
Terme général renvoyant aux phénomènes de tolérance et de pharmacodépendance. Le terme accoutumance est rarement utilisé en français qui utilise plutôt le terme toxicomanie.

Addiction
Certains auteurs utilisent ce terme issu de l'anglais pour désigner le processus par lequel un comportement, pouvant permettre une production de plaisir et d'écarter une sensation de malaise interne, est employé de façon caractérisée par l'impossibilité répétée de contrôler ce comportement et sa poursuite en dépit de la connaissance de ses conséquences négatives. Ces auteurs le préfèrent au concept de dépendance, celui-ci ne permettant pas de travailler sur la période qui précède la dépendance. Nous lui préférons le terme dépendance.

Agoniste
Se dit entre autres d'une substance qui agit sur un récepteur pour produire certaines réponses.

Anandamide
Neurotransmetteur agoniste du système cannabinoïde endogène. Bien que les rôles spécifiques de ces neurotransmetteurs ne soient pas encore définis, ils semblent agir comme des neuromodulateurs ; en effet, le THC augmente la libération de dopamine du noyau accumbens et du cortex préfrontal.

Cannabinoïdes
Récepteurs endogènes des molécules actives du cannabis, notamment le THC. Deux récepteurs endogènes ont été identifiés : CB_1 existent en grande densité dans l'hippocampe, le ganglion basal, les corps cérébelleux, et le cortex cérébral et CB_2, ils sont particulièrement abondants dans le système immunitaire Les effets centraux du cannabis semblent être exclusivement reliés aux récepteurs CB_1.

Cannabis
Il existe trois variétés de plantes de cannabis, le *cannabis sativa*, le *cannabis indica*, et le *cannabis ruredalis*. La plante de la variété *cannabis sativa* est la plus répandue poussant dans presque tous les sols. La plante de cannabis est connue en Chine depuis environ 6000 ans. À partir des sommités florifères de la plante de cannabis, mais aussi parfois des feuilles, on obtient le tabac à fumer. Sous cette forme, l'appellation la plus courante est le pot, mais on le désigne aussi sous le nom de mari, herbe, dope, ganja. La résine extraite de la plante sert à fabriquer le haschich.

Généralement classifié sous les psychotropes, le cannabis est un perturbateur du système nerveux central. Le cannabis contient plus de 460 produits chimiques connus, dont plus de 60 sont désignés sous le nom de cannabinoïdes. Le principal ingrédient actif du cannabis est le delta-9-tétrahydrocannabinol, communément appelé THC. D'autres cannabinoïdes présents incluent le delta-8-tétrahydrocannabinol, le cannabinol et le cannabidiol mais ils sont présents en faibles quantités et n'exercent pas d'effets significatifs sur le comportement des individus, comparativement au THC. Ils peuvent cependant contribuer à moduler l'effet global du produit. Dans le rapport, nous utilisons le terme cannabis pour désigner l'ensemble des produits, et n'utilisons marijuana ou haschich que lorsque nous désignons ces dérivés spécifiquement.

Commission sur les drogues (CND)
La Commission sur les narcotiques a été créé en 1946 par le Conseil économique et social des Nations Unies. La Commission est le principal organisme d'élaboration de politiques sur les drogues au sein du système onusien. Elle examine la situation mondiale relativement à l'abus de drogues et fait des propositions pour renforcer le contrôle international des drogues.

Conduite (ou usage) à risque
Comportement d'usage qui met la personne à risque de développer des problèmes de dépendance à la substance. La conduite à risque se compose de l'interaction complexe entre au moins quatre facteurs : le contexte d'usage, la quantité consommée, la fréquence de la consommation et la durée et l'intensité de la consommation. (Nous proposons des critères à la conclusion du rapport).

Conventions internationales
Sous l'égide de la Société des Nations en 1908 puis des Nations Unies, diverses conventions internationales réglementent la possession, l'usage, la fabrication, la distribution, le commerce, etc., des substances psychotropes. Les trois principales conventions sont celles de 1961, 1971 et 1988. Le Canada a ratifié ces trois conventions. Ces conventions, dont l'application est assujettie aux lois constitutionnelles des signataires, établissent un système de réglementation où seuls les usages aux fins médicales et scientifiques sont permis. Ce système est axé sur la prohibition des plantes source (coca, opium et cannabis) et sur le contrôle des dérivés synthétiques fabriqués par les compagnies pharmaceutiques.

Décriminalisation
Opération consistant à retirer un comportement de la «compétence » du système de justice criminelle. On distingue habituellement entre *décriminalisation de droit (ou de jure)* impliquant une modification *législative* du Code criminel (ou de toute loi de nature criminelle)et *décriminalisation de fait (ou de facto)* où il s'agit d'une décision administrative de ne pas poursuivre le comportement qui demeure cependant illégal. La décriminalisation ne concerne que le Code criminel (ou toute loi de nature criminelle), et ne signifie pas que l'on retire la compétence du système juridique dans son ensemble. D'autres lois non criminelles peuvent réguler et contrôler le comportement qui a été décriminalisé (infractions civiles, réglementaires, etc.).

Déjudiciarisation
Réfère aux mesures alternatives à la poursuite ou à la condamnation pénale d'un acte qui demeure par ailleurs prohibé. La déjudiciarisation peut se faire avant la mise en accusation, par exemple si la personne inculpée consent à suivre un traitement. Elle peut aussi se faire au moment de la sanction, et prend alors la forme de sanctions de travail communautaire ou de traitement.

Demi-vie
Temps requis pour la diminution de moitié de la concentration d'une drogue dans le sang. La demi-vie d'élimination du THC est en moyenne de 4,3 jours. Suite au phénomène de tolérance métabolique, les consommateurs réguliers métabolisent et excrètent le produit plus rapidement que les usagers occasionnels. D'autre part, à cause de sa très grande liposolubilité, l'administration répétée du THC provoque son accumulation dans les graisses. Du fait de ce stockage graisseux, la demi-vie d'élimination tissulaire du THC peut atteindre 7 à 12 jours chez les consommateurs réguliers. La consommation prolongée du cannabis se traduit donc par une période d'élimination plus longue du THC. Ainsi, même après une semaine, 20 à 30 % du THC administré et ses métabolites demeurent dans l'organisme. Le THC et ses métabolites sont graduellement excrétés dans l'urine (environ un tiers) et dans les matières fécales (environ deux tiers). Des traces de THC ou de ses métabolites peuvent être détectées dans l'urine jusqu'à 30 jours après sa consommation

Dépénalisation
Opération consistant à modifier les peines (sanctions) associées à un acte dans le Code criminel. La dépénalisation signifie la plupart du temps le fait d'abroger les dispositions permettant une sanction d'incarcération.

Dépendance
État où l'usager de drogue continue de consommer même si l'usage entraîne des problèmes qui peuvent être d'ordre physique, psychologique, relationnel, familial, ou social. La dépendance est un phénomène complexe qui peut avoir des composantes génétiques. La dépendance psychologique renvoie aux effets psychiques caractérisés par le désir insistant et persistant de consommer la drogue. La dépendance physique renvoie aux mécanismes d'adaptation de l'organisme à la consommation prolongée et peut s'accompagner d'une tolérance acquise. L'Association psychiatrique américaine propose 7 critères (voir chapitre 7).

Dopamine
Neuromédiateur impliqué notamment dans les mécanismes de perception du plaisir.

Drogue
Terme qui renvoie généralement aux substances illicites par opposition à d'autres substances telles l'alcool, la nicotine ou des médicaments psychotropes. En pharmacologie, le terme réfère à tout agent chimique qui modifie les processus biochimiques ou physiologiques des tissus ou de l'organisme. En ce sens, le terme drogue s'applique à toute substance qui est consommée principalement pour ses effets psychoactifs.

Effets aigus
Se dit des effets résultant de l'action ponctuelle d'un médicament et généralement des effets à court terme. Ces effets peuvent être centraux (sur les fonctions cérébrales) ou périphériques (sur le système nerveux).

Effets chroniques
Se dit des effets qui se développent avec le temps, à la suite de la prise ou de l'administration régulière d'une substance. Dans le rapport, nous avons préféré parler des conséquences de l'usage prolongé plutôt que d'effets chroniques.

Escalade (théorie de)
Théorie qui suggère une séquence progressive dans l'utilisation des drogues, nicotine, alcool, cannabis, puis les drogues « dures ». Elle repose sur une association statistique entre l'usage de drogues dures et le fait que ces personnes aient d'abord consommé du cannabis. Cette théorie n'a reçu aucune validation empirique et est tombée en désuétude.

Haschich
Résine issue de la plante de cannabis et transformée en pâte.

Intoxication
Perturbations qu'exerce une substance sur l'organisme. On distingue généralement quatre niveaux d'intoxication : légère, modérée, grave et mortelle.

Joint
Cigarette de marijuana, avec ou sans tabac. Le fait que deux cigarettes ne soient jamais identiques rend difficile l'analyse scientifique des effets du principe actif, notamment pour les études sur le cannabis thérapeutique.

Légalisation
Système de réglementation permettant la culture, production, fabrication, commercialisation, vente et usage de substances. Un système de légalisation peut être avec (réglementation) ou sans (libre marché) contrôles de l'État.

Liposolubilité
Propriété biophysique d'une substance de se répandre et se dissoudre plus ou moins facilement dans les graisses de l'organisme. Le THC est très liposoluble.

Marijuana
Nom mexicain qui désigne initialement une cigarette de mauvaise qualité. Par extension est devenu un équivalent pour désigner le cannabis.

Narcotique
Substance provoquant un état de torpeur ou un sommeil artificiel.

Observatoire européen des drogues et des toxicomanies (OEDT)
L'OEDT a été créé en 1993 pour apporter à la Communauté européenne et à ses États membres "des informations objectives, fiables et comparables au niveau européen sur le phénomène des drogues et des toxicomanies et leurs conséquences". Les informations statistiques, documentaires et techniques traitées ou produites par l'Observatoire fournissent à son audience une image d'ensemble sur le phénomène des drogues en Europe. L'Observatoire travaille uniquement dans le domaine de l'information. Il est composé d'un réseau de correspondants nationaux dans chacun des pays de l'Union.

Organe international de contrôle des stupéfiants (OICS)
L'Organe international de contrôle des stupéfiants (OICS ou Organe) est un organisme de contrôle indépendant et quasi-judiciaire chargé de l'application des conventions des Nations Unies sur les drogues; il a été créé en 1968 par la Convention unique sur les stupéfiants de 1961. Il a eu des prédécesseurs créés par les précédentes conventions sur les drogues, dès l'époque de la Société des Nations. L'organe est maintenant chargé de faire des recommandation à la

Commission sur les narcotiques relativement aux substances à placer dans les annexes des conventions.

Organisation mondiale de la santé (OMS)
Créée en 1948, l'OMS est l'agence des Nations Unis spécialisée dans les questions de santé. Son mandat est de favoriser le plus haut degré de santé possible. La santé est définie comme un état global de bien-être physique, psychologique et social et non seulement comme l'absence de maladie ou d'infirmité.

Office of national drug control policy (ONDCP) USA
Office national sur la politique de contrôle des drogues. Créé en 1984 sous la présidence Reagan, l'Office relève de la Maison Blanche. L'Office coordonne la politique américaine sur les drogues et gère un budget d'environ 18 milliards $ US par année.

Opiacé
Substance contenant de l'opium ou exerçant une action comparable à celle de l'opium.

Pharmacodépendance
Voir dépendance.

Porte d'entrée (théorie de la)
Aussi nommée théorie de l'introduction. Semblable à la théorie de l'escalade mais renvoie plus spécifiquement au fait que les personnes qui se procurent du cannabis viennent en contact avec des milieux potentiellement criminogènes du fait que le cannabis soit illégal.

Programme des Nations Unies pour le contrôle international des drogues (PNUCID)
Mieux connu sous l'acronyme anglais UNDCP. Fondé en 1991, le Programme a pour objectif d'informer le monde sur les dangers de l'abus de drogues. Le programme vise à renforcer l'action internationale contre la production, le trafic et la criminalité reliée aux drogues en proposant des programmes de développement alternatif, de monitoring des cultures et de lutte au blanchiment d'argent. Le programme d'évaluation globale veut aussi fournir des données fiables et le programme d'assistance juridique aide les pays à rédiger des lois adéquates ainsi qu'à former le personnel du système de justice. Le PNUCID relève du Bureau des Nations Unies pour le contrôle des drogues et la prévention du crime.

Prohibition
Terme issu historiquement de la prohibition de l'alcool aux États-Unis entre 1919 et 1933. Par extension, ce terme renvoie aux politiques poursuivies par les États et par les Nations Unies qui visent une société sans drogue. La prohibition est un système fondé sur l'interdiction de la fabrication et de l'usage de drogues à l'exception des usages scientifiques et médicaux.

Psychotrope
Substance qui agit sur le psychisme en modifiant le fonctionnement mental, entraînant des changements dans les perceptions, l'humeur, la conscience, le comportement et diverses fonctions psychologiques et organiques. De manière spécifique réfère aux médicaments utilisés dans le traitement de désordres mentaux, tels les neuroleptiques, les anxiolytiques, etc. Renvoie aux médicaments couverts par la Convention de 1971.

Réglementation
Système de contrôle qui précise les conditions sous lesquelles il est permis de fabriquer, produire, commercialiser, prescrire, vendre ou acheter une substance. La réglementation peut être axée sur la prohibition (comme c'est le cas actuellement pour les drogues illicites) ou sur l'accès contrôlé (comme pour les médicaments psychotropes et l'alcool). Notre proposition de régime d'exemption sous conditions repose sur une approche réglementaire.

Société des Nations (SDN)
Prédécesseur de l'ONU, la SDN était l'organisation internationale des états jusqu'en 1938.

Stupéfiant
Se dit souvent des substances dont les effets psychoactifs peuvent entrainer des effets de tolérance et de dépendance. Plus correctement, ce terme ne devrait s'utiliser que pour désigner les dépresseurs du système nerveux central tels les opiacés.

Substance psychoactive
Substance qui modifie les processus mentaux tels la pensée ou les émotions. Terme plus neutre que drogue, et qui ne distingue pas les substances selon leur statut juridique (licites, illicites) c'est celui que nous préférons utiliser dans le rapport.

Tétrahydrocannabinol (Δ9-THC)
Principal composant actif du cannabis, le Δ9-THC est très liposoluble, a une demi-vie d'élimination très longue, et ses effets psychoactifs sont modulés par les autres cannabinoïdes du cannabis. À l'état naturel, le cannabis contient entre 0,5 % et 5 % de concentration en THC. Les modes de culture sophistiqués, la sélection des plants, le choix entre des plants femelles, permettent d'atteindre des concentrations plus élevées, pouvant dans certains cas aller jusqu'à 30 %.

Tolérance
État induit par la consommation chronique d'une substance menant à une diminution de la réponse de l'organisme et une capacité plus grande de supporter ses effets.

Toxicité
Qualité spécifique à une substance d'entrainer l'intoxication. Le cannabis a une toxicité très faible et ne présente à peu près aucun risque de surdose.

Toxicomanie
Terme le plus fréquemment utilisé en langue française pour désigner les phénomènes que l'anglais désigne sous le terme *addiction*. Usage répété d'une ou plusieurs substances de telle sorte que l'usager (alors désigné sous le terme «toxicomane ») est en état régulier ou chronique d'intoxication, ressent le besoin de consommer, a de la difficulté à cesser la prise, et cherche à se procurer la substance. Cet état est généralement caractérisé par la tolérance et la dépendance à la substance ainsi que par un usage compulsif. Malgré son usage répandu, l'OMS a recommandé dès 1960 d'en abandonner l'usage pour cause d'imprécision, et de lui préférer le terme de dépendance.

PARTIE III

POLITIQUES ET PRATIQUES AU CANADA

CHAPITRE 11

UNE STRATÉGIE CANADIENNE ANTIDROGUE?

Les usages de substances psychoactives, licites et illicites, ont diverses conséquences sur la société canadienne, positives et négatives, directes et indirectes. La partie précédente a démontré que la consommation de substances psychoactives (licites comme illicites) est un phénomène répandu, autant chez les adultes que les jeunes du pays. Nous avons aussi vu que certaines formes d'usages peuvent entraîner des problèmes pour les usagers et leur environnement social. Ces constats suggèrent que les enjeux des substances psychoactives, du cannabis en particulier, devraient représenter une priorité pour tout gouvernement et la société en général.

Or, plusieurs Canadiens seront probablement étonnés d'apprendre que le Canada n'a financé une stratégie canadienne sur les drogues qu'entre 1987 et 1993. Certes, les législations criminelles sur les drogues n'ont pas manqué depuis l'adoption de la *Loi prohibant l'importation, la fabrication et la vente de l'opium à toutes fins autres que celles de la médecine* en 1908. Plusieurs lois pénales ont été adoptées depuis qui ont considérablement augmenté le champ d'application de la loi ainsi que la liste des substances contrôlées.[1] De manière générale, ces lois se sont concentrées sur la lutte contre l'offre et la demande, consacrant une approche prohibitionniste envers l'usage des drogues illicites, incluant le cannabis. Mais une législation pénale ne constitue pas une politique publique : elle n'en est qu'une composante. D'ailleurs, au cours des dernières années, plusieurs analystes ont souligné la nécessité d'une approche plus équilibrée pour mieux répondre aux enjeux de l'abus de substances psychoactives.

Ce chapitre retrace les étapes entourant l'élaboration et la mise en place de la Stratégie canadienne antidrogue de 1987. Cette stratégie avait précisément pour objectif de promouvoir une approche équilibrée. Nous verrons quelles en étaient les composantes et comment elle a été mise en œuvre.

---

[1] Le chapitre 12 examine l'évolution du contexte législatif du Canada relativement aux substances psychoactives.

PHASE I – ÉLABORATION ET MISE EN PLACE

En mai 1987, le gouvernement fédéral a annoncé la mise en place d'un plan d'action quinquennal financé à hauteur de 210 millions $ pour lutter contre l'abus de drogues. Le gouvernement indiquait que ce plan d'action répondait aux préoccupations croissantes associées à l'augmentation des problèmes liés à la drogue. D'autres ont suggéré que «cette mesure politique sévère était, sans aucun doute, influencée par la plus récente lutte antidrogues américaine ».[2]

Intitulée *Action contre les drogues*, la Stratégie canadienne antidrogue (SCA) avait été placée sous la responsabilité du ministre de la Santé et du Bien-être social[3] mais, afin de coordonner l'action stratégique du gouvernement fédéral en matière d'abus de drogues, elle impliquait plusieurs autres ministères. La SCA devait « réduire les préjudices causés par la consommation d'alcool et d'autres drogues aux personnes, aux familles et aux communautés, grâce à une approche équilibrée acceptable pour les Canadiens »[4]. Les gouvernements provinciaux et municipaux, les entreprises, les autorités policières, les organismes professionnels et bénévoles étaient les autres partenaires du gouvernement fédéral.

Le gouvernement fédéral reconnaissait que par le passé il avait essentiellement mis l'accent sur les mesures de contrôle de l'offre, tandis que les communautés, les provinces et les territoires, ainsi que plusieurs groupes professionnels et bénévoles avaient plutôt mis l'accent sur la réduction de la demande de drogues par la prévention et le traitement. Bien que conforme à la séparation constitutionnelle des pouvoirs entre les ordres de gouvernement, cette division des responsabilités avait limité la capacité à établir une stratégie nationale globale.

> *« En raison de la séparation des pouvoirs entre les provinces canadiennes et le gouvernement fédéral, une action contre les drogues et l'alcool complète et concertée s'avère très difficile à mettre en place. Par exemple, la plupart des stratégies de programmes servant à la prévention sont, généralement, associées aux systèmes de santé ou d'éducation; ce sont des sujets relevant de la juridiction provinciale, sur lesquels le gouvernement fédéral n'a que peu de contrôle direct. Par contre, alors que les activités policières sont contrôlées au niveau municipal, dans la plupart des cas, les autorités relèvent du gouvernement fédéral; ce dernier a donc un important contrôle. »*[5]

Reconnaissant que les provinces, les territoires et les collectivités locales avaient créé plusieurs programmes novateurs de counselling, de thérapie et de traitement, développant ainsi une expertise forte en ces matières, le gouvernement fédéral

---

[2] Giffen, P.J., Endicott, S., et S. Lambert, (1991) *Panic and Indifference: The Politics of Canada's Drug Laws*, Ottawa : Centre canadien de lutte contre l'alcoolisme et les toxicomanies, page 587.

[3] Gouvernement du Canada, communiqué de presse, *Federal Government Launches Co-ordinated Action on Drug Abuse*, 25 mai 1987.

[4] Gouvernement du Canada, (1988) *Action contre les drogues : bilan et perspectives nouvelles*, page 5.

[5] Giffen, P.J. et coll., *op. cit.*, page 585.

constatait aussi l'absence d'un mécanisme fort de collaboration nationale. Le cadre de travail national de la SCA visait à combler cette lacune, le gouvernement présentant la Stratégie comme un « programme de coopération qui regroupe les efforts et les ressources du gouvernement fédéral avec celles des gouvernements provinciaux et territoriaux et des organismes de lutte contre la toxicomanie partout au Canada ».[6]

La SCA reposait sur six composantes : éducation et prévention, application de la loi, traitement, coopération internationale, recherche et information, et priorités nationales. Des 210 millions $ de fonds fédéraux attribués à l'amélioration des programmes existants et au financement de nouvelles initiatives, 20 millions $ ont été versés la première année, 40 millions $ la deuxième et 50 millions $ chacune des trois dernières années de la stratégie. Le plan d'action prévoyait que 70 % des ressources devait servir à l'éducation et à la prévention (32 %), ainsi qu'au traitement (38 %) ; 20 % à l'application de la loi ; et le dernier 10 % à l'information et la recherche (6 %), à la coopération internationale (3 %) et à l'intérêt – *focus* – national (1 %).[7] L'équilibre recherché dans la stratégie devait donc se concrétiser dans l'allocation des fonds : même si les autorités policières recevaient de nouvelles ressources pour combattre l'offre, la majeure partie des budgets étaient consacrés à la réduction de la demande.[8] Selon des renseignements fournis par Santé Canada, les ressources ont bel et bien été attribuées tel que prévu.

Les objectifs et initiatives de la SCA se déclinaient comme suit :

Prévention, traitement, recherche et contrôle[9]

- Pour mieux sensibiliser et informer le public :
  - Élaboration d'une campagne médiatique de concert avec les provinces ;
  - Parrainer la Semaine de sensibilisation aux drogues ;
  - Installer des lignes téléphoniques de renseignements.

- Pour encourager l'implication dans les activités de prévention :
  - Appuyer l'élaboration d'actions de prévention dans les communautés ;
  - Soutenir l'élaboration de programmes novateurs de traitement au niveau communautaire ;
  - Élaborer et améliorer les programmes et documents de formation ;

[6] Gouvernement du Canada, *Action contre les drogues : bilan et perspectives nouvelles*, 1988, page 7.
[7] *Ibid.*
[8] De 1987 à 1991, un montant additionnel de 19,5 millions $ a été versé à la Stratégie nationale de lutte contre la conduite avec facultés affaiblies. Cette stratégie comprenait des programmes nationaux de sensibilisation, des programmes d'éducation routière, des sondages nationaux et des centaines d'initiatives municipales dont l'objectif était de rendre la conduite en état d'ébriété socialement inacceptable pour les Canadiens.
[9] Gouvernement du Canada, *National Drug Strategy: Prevention, Treatment, Research, Control Components*, 25 mai 1987.

- Tenir une Conférence d'action nationale sur l'usage des drogues.

❖ Pour favoriser les initiatives en matière de prévention destinées à des groupes particuliers :
- Soutenir des initiatives susceptibles d'améliorer les habiletés sociales des jeunes et leurs aptitudes à l'emploi ;
- Soutenir les projets pilotes des autorités policières pour la prévention auprès des jeunes en milieu scolaire, ainsi que pour les jeunes à risque en milieu urbain et les communautés Autochtones ;
- Réviser les programmes de lutte à la consommation de drogues chez les Autochtones ;
- Élaborer de nouvelles initiatives visant les jeunes Autochtones ;
- Soutenir les actions de partage d'expérience entre les communautés du Nord en bordure de l'Arctique.

❖ Pour encourager la création de services de traitement plus efficaces et mieux adaptés aux besoins :
- Examiner les programmes de partage de coûts du gouvernement fédéral pour soutenir la création de nouveaux programmes de réadaptation et de traitement ou l'amélioration des programmes existants ;
- Implanter des mesures pour mieux détecter les problèmes de toxicomanie parmi les professionnels de la santé et soutenir leur réadaptation ;
- Établir un comité consultatif sur la méthadone et sur les mesures à prendre pour éviter son trafic illégal ;
- Élaborer du matériel de formation et d'information destiné aux professionnels de la santé et des autres personnes qui travaillent dans le domaine de la toxicomanie ;
- Examiner les actions menées pour répondre aux problèmes de la consommation de drogues en milieu de travail ;
- Déployer des efforts soutenus aux plans national et international pour éliminer la consommation de drogues illicites dans le sport.

❖ Pour mettre à jour et améliorer les lois et les règlements antidrogue du Canada :
- Déposer un projet de loi pour remplacer l'ancienne *Loi sur les stupéfiants* et *Loi sur les aliments et drogues* ;
- Améliorer la coordination entre les organismes fédéraux et provinciaux pour une meilleure réglementation entourant la consommation de drogues ;
- Augmenter la capacité du gouvernement fédéral à identifier, analyser et surveiller les drogues ;

- Adopter des politiques coordonnées touchant l'offre de drogues illicites au Canada.

❖ Pour améliorer les connaissances dans le domaine de la consommation de drogues :

- Soutenir la recherche sur les tendances et les cycles de la consommation de drogues, et sur la prévention et le traitement ;
- Mener une étude et faire des recommandations sur les besoins prioritaires en matière de données.

❖ Pour assurer un engagement à long terme, parce que l'abus de drogues demande des solutions à long terme :

- Créer un groupe de travail qui examinera les divers moyens susceptibles de faire en sorte que l'expertise et l'expérience des provinces profitent au pays tout entier, et qui assurera la continuité de l'engagement national à connaître et prévenir l'usage des drogues.

L'application de la loi[10]

❖ Pour renforcer et mieux coordonner l'application de la loi sur les drogues :

- Renforcer les services de renseignements sur les drogues de la GRC et ses mécanismes de liaison avec les autres corps policiers ;
- Adopter une approche coordonnée en matière de surveillance côtière pour contrer le trafic des stupéfiants ;
- Améliorer la coordination entre les différents services fédéraux, ainsi qu'entre les organismes fédéraux et provinciaux.

❖ Pour réduire la rentabilité et les profits issus du trafic des stupéfiants :

- Renforcer le Programme des enquêtes économiques antidrogue de la GRC et mieux informer le public des activités et objectifs de ce programme ;
- Améliorer les techniques pour retracer les fonds illicites.

❖ Pour renforcer les efforts du Canada au niveau international :

- Assurer une formation spéciale par la GRC en matière de lutte antidrogue destinée aux policiers œuvrant dans les pays producteurs de drogues ou dans ceux où elles transitent.

❖ Pour mieux sensibiliser et informer le public sur l'abus de drogues :

- Augmenter la capacité de la GRC à faire de la sensibilisation aux drogues.

---

[10] Gouvernement du Canada, *National Drug Strategy: Enforcement Components*, 26 mai 1987.

- Pour répondre aux problèmes de consommation de drogues dans les établissements correctionnels fédéraux :
  - Mener une étude sur la consommation de drogues chez les détenus, ainsi qu'une étude sur l'efficacité des programmes de traitement présentement offerts dans les établissements correctionnels ;
  - Améliorer les mécanismes de contrôle des stupéfiants dans les pénitenciers ;
  - Élaborer des programmes pour les détenus aux prises avec des problèmes de consommation de drogues, afin de faciliter leur réinsertion dans la communauté ;
  - Améliorer les programmes de prévention par la formation du personnel, et créer des programmes d'information pour les détenus.

Répression du trafic[11]

- Pour renforcer la capacité de Douanes Canada à réprimer le trafic des stupéfiants au Canada :
  - Augmenter les ressources de Douanes Canada, afin de renforcer ses capacités dans les domaines critiques du ciblage et de l'examen des marchandises à risque élevé transportées par cargo ou par des voyageurs quel que soit le mode de transport, ainsi que d'examen du courrier à haut risque ;
  - Acquérir des détecteurs à rayons X pour accroître les capacités de détection des drogues durant l'examen des cargos, des bagages et du courrier ;
  - Étendre le Service de chiens détecteurs de Douanes Canada à tous les bureaux régionaux des douanes au Canada, et augmenter ses capacités actuelles dans les points d'entrée les plus occupés ;
  - Améliorer la formation des inspecteurs des douanes pour qu'ils puissent mieux identifier les passeurs de drogues et les envois commerciaux à risque élevé ; cette formation permettra aux inspecteurs des douanes de mieux reconnaître les indicateurs pertinents durant l'examen d'une personne ou d'un envoi commercial ;
  - Accentuer l'implication de Douanes Canada dans les programmes Info-Crime des forces policières municipales partout au Canada ;
  - Améliorer la coopération avec les lignes aériennes et les sociétés de transport maritime œuvrant dans le domaine du transport international des personnes et des marchandises, pour qu'elles aident Douanes Canada à détecter les drogues illicites destinées au marché canadien ;

---

[11] Gouvernement du Canada, *National Drug Strategy: Interdiction Components*, 27 mai 1987.

- Coopérer avec les services de douanes étrangères pour mieux cibler les passeurs de drogues en transit.

❖ Pour assurer l'application de politiques appropriées en immigration :
- Réviser les politiques d'immigration concernant les trafiquants de drogues.

International[12]

❖ Pour s'assurer que le Canada joue un rôle actif dans les forums internationaux sur la consommation de drogues :
- Participer activement à la Conférence internationale sur l'abus et le trafic illicite des drogues qui a eu lieu à Vienne, du 17 au 26 juin 1987 ;
- Adhérer à la Convention de 1971 sur les substances psychotropes des Nations Unies ;
- Augmenter la contribution du Canada au Fonds des Nations Unies pour la lutte contre l'abus des drogues (FNULAD), qui devait atteindre 1 million $ en 1991 ;
- Prendre en compte la réduction de la consommation de drogues comme facteur d'évaluation des demandes d'aide soumises à l'Aide publique au développement
- Tenir une conférence internationale d'experts sur les méthodes de dépistage biologique des drogues.

❖ Pour mieux sensibiliser et informer le public :
- Mieux informer les Canadiens voyageant à l'étranger sur les dangers associés à la possession de drogues illicites dans les pays étrangers.

Produits de la criminalité[13]

❖ Pour rendre moins rentable le trafic de drogues illicites :
- Adopter une loi sur les produits de la criminalité.

Création du Centre canadien de lutte contre l'alcoolisme et les toxicomanies

Créé en 1988 par une loi du Parlement, le Centre canadien de lutte contre l'alcoolisme et les toxicomanies (CCLAT) est un organisme non gouvernemental dont la mission est de promouvoir « la sensibilisation des Canadiens envers les problèmes de

---

[12] Gouvernement du Canada, *National Drug Strategy: International Components*, 28 mai 1987.
[13] Gouvernement du Canada, *National Drug Strategy: Proceeds of Crime Components*, 29 Mai 1987.

consommation d'alcool et de drogues, et leur participation accrue relativement à la réduction des préjudices associés à cette consommation; il doit promouvoir l'utilisation et l'efficacité de programmes d'excellence associés à la consommation d'alcool et de drogues. »[14] Plus spécifiquement, il a pour objectifs de :

- Promouvoir et appuyer la consultation et la coopération entre les gouvernements, les entreprises et les syndicats, les organismes professionnels et bénévoles, pour ce qui est des sujets touchant la consommation d'alcool et de drogues.
- Contribuer au partage efficace des renseignements sur la consommation d'alcool et de drogues.
- Faciliter et contribuer à l'élaboration et l'application des connaissances et de l'expertise dans le domaine de la consommation d'alcool et de drogues.
- Promouvoir et appuyer l'élaboration de politiques et de programmes réalistes et efficaces pour réduire les préjudices associés à la consommation d'alcool et de drogues.
- Sensibiliser de façon accrue, les Canadiens relativement à la nature et à la portée des efforts déployés au niveau international pour réduire la consommation d'alcool et de drogues, et en appuyant la participation du Canada dans ses efforts.[15]

Le Centre doit donc offrir vision et leadership dans le domaine de la réduction des préjudices associés à la consommation d'alcool et de drogues. Il travaille de concert avec les partenaires fédéraux et provinciaux, autant gouvernementaux que non gouvernementaux. Tel que l'indiquait la SCA, le gouvernement reconnaissait ainsi la nécessité d'une réponse coordonnée et regroupant tous les partenaires pour trouver des solutions à long terme. La coopération et la coordination sont des fonctions clés du CCLAT.

> *« Le Centre travaille avec le secteur privé, les organismes de lutte contre la toxicomanie provinciaux et plusieurs groupes d'intérêt spéciaux pour que tous les Canadiens puissent tirer profit des meilleurs programmes de prévention. À cette fin, il s'assure que les gens travaillant dans le domaine savent ce qui se passe dans le pays. »* [16]

Le CCLAT doit fournir « des renseignements et des politiques crédibles et objectifs sur les toxicomanies au gouvernement fédéral, aux secteurs privé et sans but

---

[14] *Loi sur le Centre canadien de lutte contre l'alcoolisme et les toxicomanies*, L.R., 1985, chapitre 49 (4e suppl.), article 3.

[15] *Ibid.*

[16] Gouvernement du Canada, *Stratégie canadienne antidrogue*, 1991, page 4.

lucratif, aux gouvernements provinciaux et territoriaux et aux gouvernements municipaux.[17] Il a établi les sept objectifs suivants :

- Élaboration des politiques
  - Objectif 1 : Suivre les développements dans les domaines de la recherche et des politiques, et soumettre des avis éclairés sur des sujets d'importance nationale.

- Développement des connaissances
  - Objectif 2 : Maintenir et améliorer continuellement les données nationales sur la nature, la portée et les conséquences de la consommation de drogues et du jeu compulsif au Canada.

- Élaboration de meilleures pratiques
  - Objectif 3 : Suivre l'évolution des programmes et pratiques importants, et contribuer à l'identification et à la diffusion des meilleures pratiques.

- Communications
  - Objectif 4 : Élaborer une stratégie de communication comprenant des activités et documents d'information afin de sensibiliser les Canadiens sur les problèmes de toxicomanies, et d'influencer et informer le public cible.
  -

- Développement du réseau
  - Objectif 5 : Élaborer, coordonner et soutenir les réseaux pour améliorer le partage de l'information et de l'expertise et leur mise en application.

- Service d'information et de référence
  - Objectif 6 : Maintenir un service d'information et de référence efficace et proactif.

---

[17] *Rapport du vérificateur général du Canada à la Chambre des communes*, 2001, Chapitre 11, «Les drogues illicites – Le rôle du gouvernement fédéral », page 6.

- Administration/gestion
  - Objectif 7 : D'organiser l'élaboration de ses politiques, son administration et ses ressources humaines de façon efficace et financièrement responsable.[18]

L'une des principales contributions du CCLAT a été la création du Centre national de références sur l'alcoolisme et les toxicomanies qui relie les principales sources d'information sur l'alcoolisme et les autres drogues en un seul réseau informatique.

Le CCLAT, sous la direction du ministre de la Santé, a une structure corporative, dotée d'un président et d'un conseil d'administration. Il est financé par la SCA et par les revenus que ses activités génèrent. Au départ, le Centre disposait d'un financement annuel de base de 2 millions $. Par contre, suite à l'Examen des programmes de 1997, son financement de base a été réduit à 500 000 $. En raison de cette mesure, presque tous les employés à temps plein ont été mis à pied. Michel Perron, le directeur général du CCLAT, nous a indiqué que les coupures budgétaires ont influé sur la capacité du CCLAT d'exécuter son mandat.

> *« Depuis 1997, le CCLAT a survécu en travaillant à contrat pour certains ministères. Ces contrats ont assuré notre survie, mais ont nui, de façon importante, aux efforts que nous avons déployés pour exécuter notre mandat statutaire d'une manière proactive. »*[19]

Au début de 2002, le gouvernement a augmenté le financement de base du CCLAT à 1,5 million $. Selon le Centre, cette augmentation lui permettra de stabiliser ses activités. Le Canada risque moins de perdre la seule mémoire collective et les seuls spécialistes en toxicomanies qui œuvrent au niveau fédéral.[20]

Création du Secrétariat de la Stratégie canadienne antidrogue

En 1990, le Secrétariat de la Stratégie canadienne antidrogue a reçu le mandat de coordonner les activités au sein du gouvernement fédéral et avec les autres gouvernements (autant au Canada qu'ailleurs dans le monde). Le Secrétariat avait plusieurs responsabilités : assurer la visibilité de la SCA, coordonner l'évaluation de la SCA et examiner le problème de la consommation de drogues d'un point de vue stratégique. Le fait d'agir comme un facilitateur était l'une de ses responsabilités clés.

---

[18] Pour obtenir de plus amples renseignements sur le Centre canadien de lutte contre l'alcoolisme et les toxicomanies, voir le site Web à http://www.ccsa.ca et le document du Gouvernement du Canada, *Stratégie canadienne antidrogue - Phase II - Situation actuelle*, Canada, 1994, pages 38-40.

[19] Michel Perron, directeur administratif, Centre canadien de lutte contre l'alcoolisme et les toxicomanies, Délibérations du Comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001-2002, 10 juin 2002, numéro 22, page 69.

[20] *Ibid.*

> *« Parmi ses fonctions importantes, le Secrétariat doit devenir une source d'information, un point d'entrée central pour le gouvernement fédéral, pour diriger les personnes qui ont des questions vers celles qui ont des réponses. Les membres du Secrétariat proposent aussi des conseils, offerts par des groupes externes, aux partenaires fédéraux. Ils essaient de regrouper les gens pour simplifier les sujets d'intérêt commun. »*[21]

En 1996, durant la Phase II de la stratégie, le Secrétariat a été démantelé. L'évaluation de la Phase II de la SCA avait suggéré que la fonction de supervision de la coordination devrait relever d'un organisme ne faisant pas partie intégrante d'un des ministères participants – sinon un tel organisme risquait de se retrouver en conflit d'intérêt réel ou perçu.[22] Par le passé, certains ont considéré le Secrétariat comme un organisme représentant principalement les intérêts de Santé Canada, plutôt qu'un organisme représentant la stratégie antidrogue.

Le Bureau de la Stratégie canadienne antidrogue du ministère de la Santé est désormais le coordonnateur de la stratégie antidrogue du gouvernement fédéral. Il se décrit comme suit :

> *« Le Bureau de la Stratégie canadienne antidrogue de Santé Canada est l'agent coordonnateur du gouvernement fédéral responsable de la réduction des méfaits ainsi que des initiatives de prévention, de traitement et de réadaptation associées aux problèmes d'alcoolisme et d'autres drogues. Nos efforts servent à éviter que des personnes qui ne consomment pas présentement de drogues commencent à le faire, à réduire les méfaits chez celles qui les consomment et à promouvoir des traitements et des réadaptations efficaces et novateurs pour celles qui ont des problèmes de consommation. Le Bureau travaille de concert avec les autres ministères fédéraux et les gouvernements provinciaux et territoriaux. Il propose un leadership national et une coordination pour les problèmes de consommation de drogues, effectue des recherches sur les facteurs de risque et les causes profondes de la consommation de drogues, résume et diffuse des renseignements et des meilleures pratiques dernier cri aux partenaires clés, et collabore avec les organismes multilatéraux pour aborder le problème international de consommation de drogues. »*[23]

Dans son rapport déposé en 2001, la vérificatrice générale a indiqué que l'autorité de Santé Canada, en tant que coordonnateur, a des limites. Elle a recommandé que le gouvernement « revoie les mécanismes en place pour le leadership et la coordination au sein du gouvernement fédéral, ainsi que les mécanismes de coordination avec les gouvernements provinciaux/territoriaux et municipaux lorsqu'ils abordent les problèmes des drogues illicites ».[24]

---

21 Gouvernement du Canada, *Stratégie canadienne antidrogue - Phase II - Situation actuelle*, Canada, 1994, pages 11-12.

22 Santé Canada, *Évaluation de la stratégie canadienne antidrogue -- rapport final*, juin 1997, page 22.

23 On peut trouver des renseignements sur le Bureau de la Stratégie canadienne antidrogue sur le site Web de Santé Canada à http://www.hc-sc.gc.ca/hppb/cds-sca/cds/about.html

24 *Rapport de la vérificatrice générale du Canada à la Chambre des communes*, 2001, Chapitre 11, « Les drogues illicites – Le rôle du gouvernement fédéral », page 24.

Nous sommes d'accord avec la conclusion de la vérificatrice générale et recommandons la création d'un poste de Conseiller national sur les substances psychoactives et les dépendances qui devrait assurer la coordination interministérielle au niveau fédéral. De plus, le CCLAT aurait le rôle de coordonnateur national de la recherche.

PHASE II - RENOUVELLEMENT

En mars et avril 1991, le gouvernement fédéral a mené une consultation nationale auprès de ses partenaires municipaux et provinciaux sur l'avenir de la SCA. Ces consultations devaient préparer le renouvellement possible de la Stratégie, recueillir des renseignements sur ses forces et faiblesses et identifier les priorités d'action. Ces consultations ont révélé que l'abus d'alcool, suivi de l'abus et la mauvaise utilisation de médicaments d'ordonnance, constituaient les problèmes de toxicomanie les plus importants au Canada. L'usage du tabac était aussi considéré comme une source importante d'abus et un problème de santé grave. Les drogues de la rue, c'est-à-dire les drogues illicites, quoique toujours préoccupantes, ne représentaient pas un problème important selon les personnes consultées. On a noté que la consommation de cannabis était toujours répandue.

Lors des consultations, plusieurs ont suggéré d'intégrer la Stratégie nationale de lutte contre la conduite avec facultés affaiblies à la SCA et souhaitaient l'adoption d'une politique nationale sur l'alcool. Certains ont aussi suggéré que l'utilisation de stéroïdes chez les athlètes et les jeunes soit intégrée à la SCA. Finalement, d'autres personnes ont demandé l'adoption d'une politique sur le tabac et l'inclusion du tabac dans la SCA. Les participants soulignaient qu'une stratégie antidrogues nécessite un engagement à long terme.

> *« Pour aborder les nombreux problèmes associés à la consommation de drogues, les participants au processus de consultation ont mis l'accent sur le besoin d'un engagement à long terme envers la SCA. Depuis des siècles, la consommation de drogues est un problème. Le fait d'obtenir des changements importants au niveau et à la nature de la consommation de drogues dans les cinq ou les dix prochaines années est irréaliste. L'impact des initiatives servant à contrer le problème de consommation de drogues ne sera peut-être pas visible avant quelques générations. C'est pourquoi la SCA doit devenir un programme permanent ayant un appui politique et gouvernemental. Le fait d'obtenir des changements sociétaux fondamentaux à long terme au niveau de l'attitude et du comportement exige un financement de base sans mesure de temporisation. »*[25]

---

[25] Gouvernement du Canada, *Canada's Drug Strategy: Consultations 1991*, page 7. Pour obtenir de plus amples renseignements sur les commentaires effectués sur les problèmes d'offre, les problèmes de demande et le rôle et l'impact de la SCA, pages 3-7.

En 1992, la Stratégie nationale antidrogue est devenue la Stratégie canadienne sur les drogues (SCD) et son financement a été porté à 270 millions $ pour une période de cinq ans. La Stratégie impliquait principalement six ministères fédéraux.[26] Donnant suite aux consultations, la Stratégie sur les drogues incorporait la stratégie nationale de lutte contre la conduite avec facultés affaiblies. Ce ne fut cependant pas le cas pour le tabac. Comme la stratégie précédente, la SCD insistait sur une approche équilibrée pour réduire la demande et l'offre associées aux drogues. Les fonds devaient être attribués comme suit : la prévention (30 %), le traitement (30 %), l'application de la loi et le contrôle du trafic (28 %), l'information et la recherche (5 %), l'intérêt –*focus* – national (5 %) et la coopération internationale (1 %). Selon Santé Canada, pendant la période de cinq ans, la SCA a reçu environ 104,4 millions $.[27] En fait, en raison des coupures dans les dépenses gouvernementales, les sommes initialement prévues ne se sont jamais matérialisées.

En accord avec les intervenants sur la nécessité d'un engagement à long terme et qu'un horizon de 5 ou même 10 ans n'était pas réaliste pour arriver à des changements importants, le gouvernement a souligné que la SCA devrait être un programme permanent engageant les partenaires (autant gouvernementaux que non gouvernementaux) à tous les niveaux (municipaux, nationaux et internationaux) dans une stratégie équilibrée.[28]

Poursuivant sur la lancée de la Phase I, la Phase II devait rendre les interventions du Canada en matière d'alcoolisme et de drogues plus efficaces pour ce qui est de la réduction des préjudices aux personnes, aux familles et aux communautés, causés par le l'usage à problème – « *problem use* » – d'alcool et de drogues. Cet objectif se déclinait comme suit :

- Mieux cibler les programmes en se concentrant sur les populations à risque élevé (surtout les jeunes enfants, les enfants de la rue, les décrocheurs, les autochtones ne vivant pas sur une réserve, les personnes sans emploi, les personnes âgées et les femmes).
- Améliorer la coordination et la collaboration entre les ministères fédéraux et les partenaires externes (gouvernements provinciaux et territoriaux, les organismes non gouvernementaux, etc.).
- Mettre au point la base d'information sur les problèmes associés à la consommation de drogues, pour aider les décideurs, les concepteurs de programme, les chercheurs,

---

[26] Santé et Bien-être social Canada, Solliciteur général Canada, Revenu Canada (Douanes et Accise), Travail Canada, Affaires étrangères et Commerce international Canada et ministère de la Justice Canada.

[27] Gillian Lynch, directrice générale, Programme de la stratégie antidrogue et des substances contrôlées, Santé Canada, Délibérations du Comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001-2002, 10 juin 2002, numéro 22, page 27.

[28] Gouvernement du Canada, *Stratégie canadienne antidrogue - Phase II*, 1992, page 3.

les professionnels et les autres personnes touchées par les problèmes de consommation à mieux répondre à ce problème.

- Augmenter les ressources permettant aux ministères de poursuivre certaines activités permanentes et de rediriger leur attention vers des problèmes émergents ou de nouvelles activités.[29]

La décision de renouveler la SCD a été accompagnée d'une condition exigeant son évaluation. En juin 1997, Santé Canada a publié un rapport sur l'évaluation de la Phase II de la SCA. Ses principales conclusions étaient les suivantes :

- Les ministères participants ont mieux ciblé leurs actions, tenant compte des variations imputables à leurs mandats respectifs;
- La coordination interministérielle au niveau opérationnel et pour les initiatives spécifiques était efficace. Par contre, la coordination interministérielle au niveau de la planification stratégique présentait des faiblesses qui n'avaient pas été réglées (des objectifs de coordination clairs n'ont pas été identifiés, et le rôle du Secrétariat de la SCD n'a pas été défini adéquatement);
- La SCA n'a pas eu de visibilité nationale ni au niveau politique ni au niveau public ;
- Suite au financement de la Phase II, la quantité de renseignements offerts au Canada sur l'abus de drogues a augmenté;
- Durant la Phase II, les ministères ont augmenté le niveau de ressources consacré aux drogues. Par contre, des coupures importantes à certains budgets ministériels ont limité l'atteinte de certains objectifs de la Phase II; et
- Les ressources de la Phase II ont été utilisées d'une façon conforme à l'approche de réduction des méfaits, même si une politique formelle de réduction des méfaits n'était pas en place durant le mandat de la Stratégie.

Notant que le leadership, la coordination et la planification stratégique étaient des éléments essentiels au succès de la Stratégie, le rapport a observé des faiblesses durant la Phase II. De plus, une vision commune et un ensemble d'objectifs clairs et mesurables, qui sont aussi des conditions fondamentales de succès, faisaient défaut, tout comme étaient floues les lignes d'imputabilité quant à l'atteinte des objectifs de la Stratégie. Comme nous le verrons un peu plus loin, la vérificatrice générale du Canada a de nouveau mentionné la plupart de ces problèmes dans son rapport 2001 (soit cinq ans plus tard).

Pour coordonner la Stratégie, deux groupes ont été créés au niveau fédéral sous la direction de Santé Canada, soit le Comité directeur des sous-ministres adjoints sur l'alcool et les autres drogues et le Groupe de travail interministériel sur l'alcool et les autres drogues. Ils ont pour mandat :

---

[29] Santé Canada, *Évaluation de la stratégie canadienne antidrogue -- rapport final*, juin 1997, page iv.

« Le Comité directeur doit se réunir au moins deux fois par année pour améliorer l'efficacité générale de la Stratégie et pour orienter le Groupe de travail. Il doit coordonner les activités fédérales, obtenir un avis consensuel relativement aux priorités, aborder les problèmes émergents et surveiller la mise en œuvre de la stratégie fédérale. » [30]

PHASE III – LE RENOUVELLEMENT SANS FINANCEMENT PRÉCIS

En 1996, la *Loi réglementant certaines drogues et autres substances* a été adoptée. Partie intégrante de la SCD, cette loi visait, selon le gouvernement, à moderniser et améliorer les politiques de lutte contre la drogue sous-jacentes aux lois précédentes, et à permettre au Canada de respecter ses obligations internationales. Nous observons au passage que, depuis l'adoption de la *Loi réglementant certaines drogues et autres substances*, la majorité des modifications apportées aux lois fédérales touchant les drogues illicites ont porté sur la réduction de l'offre.

En 1998, la SCD a été renouvelée en théorie mais sans ligne budgétaire précise, malgré les avertissements donnés quant aux conséquences négatives d'une telle décision. Une évaluation de la contribution de Santé Canada à la SCD avait observé :

« Nous devons en venir à la conclusion que des initiatives à court terme, comme la Phase II de la SCA, sont utiles, car elles inspirent un sens élevé des priorités associées à un problème particulier. En même temps, elles offrent des désavantages inhérents lorsqu'on aborde un problème, tel que celui de la consommation de drogues, qui, selon plusieurs sources, exige une intervention à plus long terme que ne le permet le financement à court terme. » [31]

Le rapport poursuivait :

« La composante de la Phase II de la Stratégie canadienne antidrogue relevant de Santé Canada a effectué plusieurs investissements dans la recherche et l'élaboration de programmes et les systèmes de suivi de l'information. Dans plusieurs domaines, Santé Canada peut tirer profit des avantages qu'offrent les connaissances acquises. Par contre, cette situation pourrait ne pas continuer en raison du non-renouvellement.

*Il existe aussi des préoccupations concernant le fait que la mesure de temporisation –*sunsetting *– de la composante relevant de Santé Canada de la Stratégie canadienne antidrogue laissera un vide et un déséquilibre dans la politique fédérale défavorable à la réduction des méfaits et conséquemment beaucoup*

[30] *Rapport de la vérificatrice générale du Canada à la Chambre des communes*, 2001, Chapitre 11, « Les drogues illicites – Le rôle du gouvernement fédéral », page 6.

[31] Santé Canada, *Évaluation de la composante relevant de Santé Canada de la Stratégie canadienne antidrogue - Rapport Final*, décembre 1996, pages 33-34.

trop concentrée sur la réduction de l'offre. La crédibilité du Canada au niveau international pourrait aussi en souffrir. »[32]

Les ministères et agences fédéraux étaient les seuls participants à ce renouvellement de la Stratégie. La SCD poursuit encore une approche équilibrée de réduction de l'offre et de la demande de drogues et a toujours pour objectif la réduction des méfaits associés à la consommation d'alcool et de drogues aux personnes, aux familles et aux communautés. Spécifiquement, la Stratégie a pour objectifs de :

- Réduire la demande de drogues ;
- Réduire les taux de mortalité et de morbidité associés aux drogues ;
- Améliorer l'efficacité et l'accès aux renseignements et aux interventions sur la consommation des substances ;
- Restreindre l'offre de drogues illicites et réduire sa rentabilité ; et
- Réduire les coûts de la consommation de drogues pour la société canadienne.[33]

La Stratégie dit se fonder sur quatre piliers : la prévention; l'application de la loi et le contrôle du trafic; le traitement et la désintoxication; et la réduction des méfaits. Dans ce cadre de travail général, elle a identifié sept composantes : la recherche et le développement des connaissances ; la diffusion des connaissances ; la prévention ; le traitement et la désintoxication ; l'application des lois et le contrôle ; la coordination nationale ; et la coopération internationale[34].

Le programme de la direction de la Stratégie antidrogue et des substances contrôlées, au sein de la Direction générale de la Santé environnementale et de la sécurité des consommateurs de Santé Canada, dépense présentement 34 millions $ chaque année pour lutter contre la consommation de drogues.[35] Le Bureau de la Stratégie canadienne antidrogue gère 16,5 millions $ du budget total. Le Programme de traitement et de réadaptation des alcooliques et toxicomanes, qui était au départ géré par le ministère des Ressources humaines, a été transféré à Santé Canada en octobre 1997. Ce programme est présentement géré par le Bureau de la Stratégie canadienne antidrogue, qui dispose d'un fonds de 14 millions $ pour les provinces aux fins des programmes de traitement et de réadaptation. Les autres 2,5 millions $ sont versés au CCLAT (1,5 millions $) et à la recherche et à la gestion des programmes (1 million $). Les 17,5 millions $ restants sont versés par la Direction générale de la Santé environnementale et sécurité des consommateurs comme suit : l'administration des règlements autres que la réglementation sur l'accès à la marijuana à des fins

[32] *Ibid.*, pages 34-35.

[33] Gouvernement du Canada, *Stratégie canadienne antidrogue*, 1998, pages 4-5.

[34] Alors que la SCD traite des drogues licites et illicites, une stratégie séparée a été élaborée pour identifier des approches spécifiques à l'usage du tabac.

[35] Ne comprend pas les dépenses effectuées par la Direction générale de la santé des Premières nations et des Inuits, qui totalisent environ 70 millions $.

médicales (5 millions $); le Programme de recherche sur l'usage de la marijuana à des fins médicinales (5 millions $); le service d'analyse des drogues (4,5 millions $); et les politiques, la recherche et les affaires internationales (3 millions $).[36]

Santé Canada engage d'autres ressources sur la consommation de drogues, par l'entremise d'activités diverses du ministère. Par exemple, la Direction générale de la santé de la population et de la santé publique offre des ressources permettant d'aborder le sujet du VIH/SISA et de l'hépatite C, ainsi que celui du syndrome d'alcoolisme foetal.

LA STRATÉGIE CANADIENNE ANTIDROGUE – UNE RÉUSSITE?

Nous n'avons pas la prétention de faire une analyse en profondeur de la SCD depuis son élaboration et son lancement en 1987. Nous pouvons par contre examiner certains objectifs clés pour déterminer si la SCA est une réussite ou non. Il est important de noter que, malgré les sommes importantes investies au niveau fédéral pour contrôler les drogues psychoactives, plusieurs personnes pensent que le Canada ne dispose pas d'une stratégie nationale antidrogue adéquatement financée.

> *« En 1997, le gouvernement a lancé un examen des programmes. D'importantes coupures budgétaires ont été faites dans tous les ministères, y compris Santé Canada. La Stratégie antidrogue a écopé et a été temporisée en 1997. En fait, aucun argent frais n'a été injecté par le gouvernement fédéral dans le domaine des toxicomanies depuis ce temps-là. Présentement, le Canada ne dispose d'aucune stratégie nationale. Nous n'avons donc aucune donnée de recherche pour nous guider. En fait, personne ne connaît la portée de la consommation de drogues ou de la prévalence des drogues au Canada, car aucune enquête n'a été effectuée depuis 1994. Nous devons donc nous fonder sur des hypothèses et utiliser d'autres outils pour obtenir un aperçu de la situation présente au Canada. »*[37]

Nous avons déjà vu au chapitre 6 que la recherche, le développement et la diffusion des connaissances sont gravement déficients au Canada, malgré que les diverses stratégies fédérales sur les drogues les aient identifiés comme éléments essentiels. Ainsi, seulement deux enquêtes épidémiologiques nationales sur l'usage de drogues ont été effectuées, la première en 1989 et la seconde en 1994. Le sous-financement chronique du CCLAT explique pour partie cette faiblesse de la recherche et du développement des connaissances. Il est évident qu'avec les moyens dérisoires qui lui étaient conférés, même dans les meilleures années, le CCLAT n'a jamais disposé du financement nécessaire au développement des connaissances sur les tendances et les coûts et conséquences de la consommation de drogues au Canada. L'augmentation récente de son budget de fonctionnement est sûrement une bonne nouvelle, mais ne

---

[36] Santé Canada, Présentation au Comité spécial sur les drogues illicites, 10 juin 2002.
[37] Michel Perron, *op. cit.*, page71.

permettra pas au Canada d'acquérir les outils nécessaires pour effectuer des recherches vitales et nécessaires dans le domaine et de se mettre au niveau de ses partenaires occidentaux en ce domaine.

Depuis sa mise en place, la SCD a dit soutenir une approche équilibrée entre la réduction de l'offre et de la demande de drogues. Il est facile de faire un énoncé de ce genre ; encore faut-il que les faits puissent le valider. Récemment, la vérificatrice générale a indiqué que, des 500 millions $ dépensés chaque année par 11 ministères ou organismes fédéraux pour combattre l'usage de drogues illicites au Canada, environ 95 % de ce montant sert à la réduction de l'offre. Évidemment, ce montant n'inclut pas les dépenses des provinces en santé (traitement) et éducation (prévention), ni non plus les dépenses qu'elles encourent au titre de l'application de la loi et de l'administration de la justice ; nous verrons au chapitre 18 que rien ne permet de penser qu'elles dépensent moins pour la répression que le fédéral. Il est difficile dans ces conditions de continuer à prétendre qu'il s'agit d'une approche équilibrée.

La coordination et la collaboration entre les ministères fédéraux, les provinces et les municipalités est un autre objectif clé de la SCD. Récemment, la vérificatrice générale a critiqué le leadership offert au niveau fédéral. Elle a recommandé la mise en œuvre d'une stratégie antidrogue comprenant une coordination fonctionnelle, ainsi que des objectifs et des résultats clairs.

> *« Le Canada a besoin d'un leadership fort et d'une coordination plus cohérente, afin d'établir une stratégie, des objectifs communs et des attentes relatives au rendement collectif. Il doit être en mesure de répondre rapidement aux préoccupations émergentes associées à la consommation ou au trafic des drogues illicites. La structure courante du leadership et de la coordination des efforts déployés par le gouvernement fédéral doit être revue et améliorée. Les mécanismes de coordination avec les provinces et les municipalités doivent aussi être revus, car ils touchent les trois paliers gouvernementaux. »* [38]

L'incapacité à évaluer l'atteinte de ses objectifs – inévitable en l'absence d'indicateurs clairs – est l'une des faiblesses évidentes de la SCA. Ainsi, aucune évaluation des programmes de prévention et de traitement n'a été financée par le gouvernement fédéral. Ce manque d'évaluation est préoccupant.

> *« Même si le gouvernement fédéral propose un leadership et une coordination pour aborder le problème de la consommation de drogues illicites, il n'a pas produit de rapport complet qui démontre comment le Canada gère le problème. Il serait logique que Santé Canada, le ministère responsable, publie les résultats des efforts que déploie le gouvernement pour réduire l'offre et la demande de drogues illicites. »* [39]

En l'absence d'outils de base pour déterminer si elle a atteint ses objectifs – études sur les tendances d'usage, étude des coûts et bénéfices, études d'impacts, et critères

---

[38] *Rapport de la vérificatrice générale du Canada à la Chambre des communes* 2001, Chapitre 11, « Les drogues illicites – Le rôle du gouvernement fédéral », page 1.
[39] *Ibid.*, page 22.

d'évaluation clairs – il est difficile de prétendre que la SCA est une réussite. Il est clair qu'elle comporte plusieurs faiblesses fondamentales. Comme plusieurs l'ont indiqué, nous devons nous poser la question de savoir si le Canada dispose réellement d'une stratégie nationale globale sur les substances psychoactives.

CONCLUSIONS

Bien que nous reconnaissions que le gouvernement fédéral ne peut pas agir seul, nos conclusions relatives à une stratégie canadienne sur les substances psychoactives sont, de façon générale, limitées au rôle que joue le gouvernement fédéral.

Conclusions du chapitre 11

- **Le Canada a un besoin urgent d'une stratégie nationale sur les substances psychoactives coordonnée et globale, pour laquelle le gouvernement fédéral doit offrir un leadership clair.**
- **Toute stratégie future sur les substances psychoactives, doit porter sur l'ensemble des substances incluant l'alcool et le tabac.**
- **Pour réussir, une stratégie nationale doit reposer sur des partenariats entre tous les paliers gouvernementaux et avec les organismes non gouvernementaux.**
- **Au fil des ans, le financement a été irrégulier, diminuant la capacité de coordonner et de mettre en œuvre la stratégie; des ressources adéquates et un engagement à long terme sont nécessaires pour que la stratégie soit une réussite.**
- **Il faut déterminer des objectifs clairs et mener des études d'évaluation complètes sur leur mise en œuvre et les résultats obtenus.**
- **Des critères clairs et partagés de réussite doivent être identifiés dès le début.**
- **Le financement de base de la SCD a été insuffisant, ce qui l'a empêché d'exécuter son mandat; le financement adéquat d'une stratégie nationale est essentiel.**
- **Un organisme indépendant comme le CCLAT est nécessaire pour effectuer des enquêtes nationales au moins tous les deux ans; il conviendrait aussi que le CCLAT travaille avec les provinces et les territoires pour que les enquêtes en milieu scolaire soient plus régulières, cohérentes et comparables.**

	➢ **La coordination, au niveau fédéral, devrait être confiée à un organisme qui ne fait pas partie intégrante d'un des ministères partenaires.** ➢ **Une stratégie nationale sur les substances psychoactives devrait adopter une approche réellement équilibrée – il est inacceptable que 95 % des dépenses fédérales en ce domaine concernent la réduction de l'offre.**

CHAPITRE 12

LE CONTEXTE LÉGISLATIF NATIONAL

La prohibition des drogues a moins de cent ans, celle du cannabis un peu plus de 75. Il est tentant de penser que les décisions prises au fil des ans de lutter contre la production et la consommation de certaines drogues au moyen du droit pénal s'inscrivent dans le droit fil du progrès social et de la mobilisation des connaissances scientifiques sur les drogues. Les sociétés d'avant le XXe siècle étaient moins « évoluées » et ne disposaient pas des outils sophistiqués que la médecine, la biologie moléculaire et la biochimie, la psychologie et les sciences cognitives, ont apportés au cours de ce siècle des révolutions technologiques. Les mesures de prohibition adoptées par les parlements et plus largement par la communauté internationale étaient donc le reflet plus ou moins exact du savoir construit peu à peu par les scientifiques. La conquête graduelle des territoires il y a peu de temps encore occupés par l'irrationnel et ses cohortes de charlatans et autres shamans, se poursuivait, pour le plus grand bien de l'humanité. Témoins, les fabuleux progrès techniques de la médecine et de la pharmacologie au cours de ce siècle qui auraient mené à l'augmentation de la longévité et surtout à la diminution de la mortalité infantile, du moins en Occident.

Mais est-ce bien le cas ? La civilisation est-elle une marche constante vers le progrès, vers une rationalité de plus en plus grande, de plus en plus invincible ? À regarder l'état de la planète et les signaux d'alarme lancés par plus d'un scientifique aujourd'hui, il est permis d'en douter. Au plan social, le XXe siècle n'a pas causé moins de guerres, de destructions, d'inégalités entre les peuples, que les siècles précédents. En matière de drogues, les législations sont-elles une traduction plus ou moins fidèle de la connaissance scientifique pour le plus grand bien de tous ? Peut-on discerner une architecture rationnelle aux lois nationales et aux conventions internationales qui régissent certaines drogues et autres substances ? Sont-elles basées sur la connaissance des effets des drogues sur le psychisme et sur le comportement humain ? Traduisent elles une volonté d'assurer le bien-être des populations ?

L'historique de la législation sur les drogues illicites au Canada, comme l'analyse que fait le chapitre 19 de l'architecture des conventions internationales, permet d'en douter fortement. Nous ne nions pas que les connaissances aient progressé ; la seconde partie de notre rapport en témoigne. Mais les connaissances scientifiques sont elles mêmes des constructions qui se produisent dans un contexte historique donné et qui répondent à des paradigmes dans la manière de poser les problèmes et de mener

des recherches. Le positivisme scientifique dominant est le résultat temporaire d'une longue évolution de la démarche de connaissance. Il n'en constitue pas la «fin de l'histoire ». Il se produit, à l'intérieur de la démarche scientifique, une « sélection » des questions pertinentes comme des manières de les poser, faisant en sorte que toute question n'est pas bonne à poser et que certaines manières d'y répondre sont plus acceptables par la communauté des chercheurs.

Par ailleurs, les législations adoptées par les parlements sont influencées au moins autant par des préjugés et préconceptions issus de la «*pop science*» que par des considérations partisanes, personnelles, internationales. Le parlementaire n'est pas, en ce sens, différent de chacun des citoyens ; c'est ce que nous rappelions dans l'introduction générale du rapport.

On ne peut comparer les effets du cannabis à ceux de l'alcool ou du tabac nous a-t-on dit à plusieurs reprises. Pourtant, sauf à risquer d'être illisible sinon irrecevable par la collectivité, une politique publique sur les «drogues » doit proposer une certaine rationalité du genre : « ceci est prohibé parce que… et cela ne l'est pas parce que… » La plupart du temps, la « raison » – ou la justification ? – se présente sous l'angle de risques ou de dangers d'une part, et de l'utilité médicale d'autre part. Ainsi, le régime actuel qui gouverne les «drogues » soutient que certaines d'entre elles, en raison des risques ou des dangers qu'elles présenteraient doivent être réglementées, c'est-à-dire qu'elles ne sont pas en vente libre. Lorsqu'elles présentent des dangers **et** qu'elles n'ont pas d'application médicale reconnue, la réglementation en prohibe la fabrication, la production, la culture, l'usage, la possession, etc. C'est le cas, dans les lois et conventions, de l'opium et ses dérivés (héroïne), de la plante de coca et ses dérivés (cocaïne, crack), et de la plante de cannabis et ses dérivés (marijuana, haschich). Lorsque la drogue présente des dangers mais qu'elle a une utilité médicale, elle est sujette à une réglementation plus ou moins sévère : c'est le cas des benzodiazépines et autres médicaments puissants, qui ne peuvent être obtenus que sous ordonnance médicale et vendus par un pharmacien. D'autres drogues présentent un « risque » pour la santé : nicotine, alcool, mais aussi plusieurs médicaments en vente libre. L'emballage doit indiquer les risques (sauf pour l'alcool – ce n'est pas anodin) de manière à « prévenir » l'usager.

Dans quelle mesure cette rationalité tient-elle la route ?

> « *Trois chercheurs de l'Université de Toronto (Lazaron, Pomeranz, Corey, 1998) ont estimé que des médicaments licites* correctement prescrits *tuaient en moyenne cent mille personnes par année en Amérique du Nord. Même si pour des raisons méthodologiques on venait à réduire ce chiffre de la moitié ou des deux tiers, il n'en illustre pas moins les énormes pertes humaines qui échappent à tout système de contrôle, y compris juridique. Or, personne ne pense écarter ce danger en interdisant les prescriptions médicales, c'est-à-dire les décisions risquées des médecins ou le « droit à la consommation » des médicaments. Pourquoi ? Parce que l'on ne voit pas comment cette solution pourrait être préférable à celle de prendre des risques de façon responsable. Face à ce problème, on essaiera alors de trouver d'autres solutions, comme un meilleur contrôle de la qualité des produits, etc. Et on ne pense pas non plus (heureusement) à attribuer une responsabilité criminelle aux médecins pour avoir pris le risque*

d'écrire une prescription correcte en étant conscients que même les médicaments correctement prescrits peuvent causer la mort. » [1]

Le rapport pour 2001 de l'Organe international de contrôle des stupéfiants fait état de l'augmentation « inquiétante » de l'abus de divers médicaments prescrits sur ordonnance aux États-Unis et note que plusieurs de ces médicaments se retrouvent sur les marchés illicites notamment par le biais de l'Internet.[2]

Le tabac ferait plus de 400 000 morts par an aux États-Unis, environ 45 000 au Canada. L'alcool quant à lui est relié aux violences et agressions physiques, notamment intraconjugales, aux accidents de la route, et l'abus cause des milliers de décès par an.

« C'est une erreur que de situer les drogues illicites dans une catégorie distincte des drogues légales, dans l'histoire de la criminalisation. Nous avons compliqué les choses, de nos jours, parce que nous ne tendons pas à voir les drogues légales sous le même jour que les drogues illicites. Pour le démontrer, nous parlons de « l'alcool et des drogues » comme si l'alcool n'était pas une drogue, comme si les agents de police qui interviennent dans les conflits familiaux ne savaient pas pertinemment que le principal problème de toxicomanie qu'ils trouveront dans ce conflit est celui de l'alcool, comme si nous ne savions pas déjà que l'alcool est un facteur essentiel dans 70 % de tous les homicides. Le fait de prétendre que la consommation de d'alcool est différente de la consommation de drogues illicites semble être une folie culturelle qui en dit long sur les oeillères culturelles que nous portons dans la vie quotidienne. » [3]

La rationalité du système de contrôle tient-elle la route aux yeux de la société civile, usagers comme non-usagers ? Quels sont les critères qui ont présidé aux décisions des législateurs ? De fait, ont-ils eu recours à des critères ? Qu'est-ce qui a motivé les parlementaires canadiens et d'ailleurs à prohiber certaines substances, à contrôler l'accès de certaines autres, et à en laisser d'autres en vente libre ?

Savoir d'où l'on vient aide à comprendre où l'on va. C'est l'ambition de ce chapitre, retraçant l'évolution de la législation canadienne sur les drogues, de 1908 jusqu'à maintenant.[4] Nous avons identifié trois périodes législatives. La première, la plus longue, va de 1908 à 1960. C'est la période que nous appelons de l'hystérie. La seconde, beaucoup plus courte, va de 1961 à 1975. C'est la période de la recherche des raisons perdues. Enfin, la période contemporaine, qui commence vraiment au début des années 1980, est la période de la fuite en avant. Comme il serait trop long de décrire les différents articles des divers projets de loi adoptés au cours des années, nous

---

[1] Pires, A.P., (2002) *op. cit.*, page 43.

[2] OICS (2002) notamment aux pages 58-60.

[3] Témoignage de Neil Boyd, professeur de criminologie, Université Simon Fraser, devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, deuxième session de la trente-sixième législature, 16 octobre 2000, fascicule 1, page 49.

[4] Ce chapitre s'inspire largement de l'excellent rapport préparé à la demande du Comité par François Dubois, assistant de recherche au bureau du sénateur Pierre Claude Nolin : *Le Parlement fédéral et l'évolution de la législation canadienne sur les drogues illicites*. Ottawa : Comité spécial du Sénat sur les drogues illicites, juin 2002. Ce rapport est disponible en ligne à www.parl.gc.ca/drogues-illicites.asp

avons inséré en annexe un tableau qui explique et présente les dispositions des lois qui furent adoptées de 1908 à 1996 sur le contrôle des stupéfiants.

1908-1960 : L'HYSTÉRIE

Au moment où se réunit la Conférence de Shanghai sur l'opium en 1909[5], l'opium, la feuille de coca, le cannabis, étaient connus depuis des centaines d'années des sociétés européennes qui les avaient découvertes au fil des contacts avec d'autres sociétés. Ces « drogues » étaient utilisées dans la pratique médicale, mais aussi par une certaine élite, mondaine ou artistique, et surtout comme outil commercial par les puissances coloniales. Dans la foulée des progrès de la chimie, le XIXe siècle avait vu l'apparition d'une quantité importante de nouvelles drogues – principalement les médicaments à base d'opiacés – et leur adoption enthousiaste par les médecins, pharmaciens, propriétaires de magasins généraux et vendeurs itinérants d'élixirs miracles. Que s'est-il passé pour que le Canada en 1908, les sept pays réunis à Shanghai en 1909, décident de prohiber cette «drogue » ? Quatre facteurs au moins forment la constellation des jeux du hasard et de la nécessité qui ont mené à la prohibition.

Des enjeux géopolitiques d'abord, notamment les relations commerciales avec la Chine et plus généralement la stabilité politique de l'Empire du Milieu, y jouent un rôle non négligeable comme le démontre le chapitre 19. Mais sur le plan interne, ces facteurs n'expliquent pas tout, d'autant que les préoccupations du Dominion du Canada et de sa population pour les enjeux de politique internationale étaient encore relativement mineures.

Dans un premier temps, les médecins ont remarqué, parfois à partir de leur expérience personnelle d'usagers, que la consommation des produits dérivés de l'opium entrainait une certaine dépendance et des problèmes de santé.[6] Au début, ces cas de toxicomanie étaient limités aux classes sociales aisées, aux artistes, qui se voyaient rarement imposer l'étiquette de «délinquants ». Cependant, l'accessibilité de plus en plus grande de ces médicaments[7] et le développement conséquent de problématiques de dépendance au sein des classes ouvrières ont profondément modifié l'opinion publique sur ces drogues. On ne parlait plus de *« malades »* mais de *« délinquants »* qui

---

[5] Voir le chapitre 19 pour plus de détails.

[6] Observons ici au passage qu'il s'agissait effectivement des dérivés synthétiques de l'opium tels la morphine. On ne redécouvrira que beaucoup plus tard que l'héroïne fumée est moins dommageable pour l'usager que l'héroïne injectée ou que des dérivés synthétiques. On peut aussi faire le parallèle avec les dérivés synthétiques du cannabis qui causeraient plus de problèmes que le cannabis fumé, comme nous l'avons vu au chapitre 9.

[7] Line Beauchesne parle d'inondation du marché par les grandes compagnies pharmaceutiques qui les fabriquaient en quantité industrielle et qu'elles cherchaient ensuite à écouler par tous les moyens. Beauchesne, L., (1991) *La légalisation des drogues… Pour mieux en prévenir les abus.* Montréal : Méridien, pages 95-96.

« ne peuvent affronter les exigences d'une vie de bon citoyen et de travailleur ».[8] Quelques médecins, soucieux de conserver leur monopole, n'ont pas hésité à réclamer des gouvernements des lois afin de restreindre l'usage des médicaments produits par les compagnies pharmaceutiques et éviter la propagation de ce «fléau» qui menaçait les fondements de la société nord-américaine.

Même si l'usage de l'opium n'a pas provoqué de crise sociale avant le début des années 1880, les Blancs qui fréquentaient les fumeries chinoises étaient souvent perçus comme suspects ou dangereux. À l'époque : *« Fréquenter le quartier chinois et ses fumeries est interprété chez plusieurs groupes moraux comme une préférence pour l'étranger, une volonté de déroger aux valeurs blanches et anglo-saxonnes. Ce jugement est encore plus sévère à l'égard des femmes. »*[9]

Associée au problème de l'alcoolisme parmi les classes ouvrières, la question des drogues devenait alors la métaphore par excellence de la dégénérescence de la civilisation occidentale judéo-chrétienne, et le cheval de bataille des ligues de tempérance aux États-Unis comme au Canada. Nés au XIXe siècle, ces mouvements avaient un fondement religieux très fort, notamment dans l'éthique protestante de la responsabilité du salut personnel par le travail et le contrôle de soi : *«la valorisation du travail et la sobriété pour éviter les pertes de production et maintenir la supériorité de la race blanche anglo-saxonne dans l'économie .»*[10] La «guerre» contre l'alcool, responsable de la violence masculine et de l'adultère, contre les drogues qui tuent la jeunesse, mais aussi contre la prostitution, les cigarettes et les jeux de hasard convenait parfaitement à ces mouvements.[11] De groupes communautaires d'entraide visant à soutenir ceux qui voulaient se débarrasser de leurs mauvaises habitudes, ces ligues se sont transformées en groupes de pression puissants pour réclamer la prohibition complète de l'alcool d'abord, soutenir ensuite celle de l'opium et des autres drogues.

Troisième facteur, étroitement relié aux deux précédents, les mouvements de population et tout spécialement l'immigration chinoise – il serait plus juste de dire l'importation de travailleurs chinois. Les Chinois avaient immigré aux États-Unis au milieu du XIXe siècle afin de travailler dans les mines et la construction de chemins de fer dans l'Ouest des États-Unis. Une fois ces grands projets terminés, certains conflits de travail éclatèrent sur la côte Ouest américaine, opposant les Chinois qui offraient leur travail à bon marché aux propriétaires d'entreprises agricoles et les puissants syndicats formés majoritairement de travailleurs blancs. Suite à l'apparition d'un mouvement antichinois d'origine syndicale et des lois qui empêchent toute nouvelle immigration chinoise, plusieurs Chinois n'auront d'autres choix que de développer le commerce de l'opium à même les ghettos où ils habitent dans les grandes villes américaines. Les mouvements de tempérance n'hésiteront pas à accaparer le sentiment raciste qui anime certains segments de la société américaine afin de dénoncer la

---

[8] Beauchesne, L. *op. cit.*, page 98.

[9] *Ibid.*, page 126

[10] Beauchesne, L. (1999) « À propos du cannabis, que faire? » *L'écho-toxico*, page 14.

[11] Ati-Dion, G., (1999) *La construction en droit international et en droit pénal canadien de la prohibition des drogues (Travail de doctorat)*, Montréal, Université de Montréal, École de criminologie, page 24.

consommation d'opium, perçue comme un fléau qui favorise l'immoralité, la criminalité et la déchéance de la race blanche et anglo-saxonne. C'est dans ce contexte d'agitation sociale, pourtant limitée à la côte Ouest américaine, que furent adoptées les premières lois aux États-Unis encadrant le commerce de l'opium.

Au Canada, les Chinois devinrent au milieu du XIXe siècle une source importante de main-d'œuvre employée dans la construction du chemin de fer Canadien Pacifique. À mesure que l'économie de la Colombie-Britannique se diversifiait, ces immigrants se sont trouvés des emplois dans les usines de transformation des produits de la pêche, les mines de charbon ou l'industrie forestière bien que les emplois disponibles pour eux demeuraient limités. Cela a aggravé l'aspect compétitif du marché local du travail et augmenté leur marginalisation au sein de la société.[12] À partir des années 1880, l'arrivée massive de Chinois, juxtaposée au ralentissement économique provoqué par la fin de la construction du chemin de fer du Canadien Pacifique et la récession économique qui a marqué la fin du XIXe siècle et les premières années du XXe siècle, ont provoqué plusieurs manifestations syndicales et populaires demandant la fin de l'immigration chinoise, source des problèmes économiques et de moralité en Colombie-Britannique.

Selon Giffen, cette crainte était injustifiée puisque l'immigration blanche en provenance d'autres régions du Canada a largement annulé l'augmentation de la population chinoise en Colombie-Britannique. En effet, la proportion de Chinois dans cette province est passée de 20 % au début des années 1880 à moins de 6 % en 1921,[13] juste avant que ne soit adoptée une disposition dans la *Loi sur l'opium et les narcotiques* autorisant la déportation d'un immigrant condamné pour une infraction liée aux drogues.

Mais :

> [Traduction] *« La tolérance pour l'habitude de fumer de l'opium s'est maintenue aussi longtemps que celle des Britanno-Colombiens pour les Chinois. Au cours des premières années du XXe siècle, le surplus de main d'œuvre et le sentiment antiasiatique dans la population se sont tous deux accentués. La Asiatic Exclusion League a été créée et fut appuyée par les chambres de commerce et les syndicats de Vancouver, d'une part, et par les députés fédéraux Conservateurs, d'autre part. La ligue était opposée aux politiques d'immigration des Libéraux [de Sir Wilfrid Laurier] et réclamait la fin de l'immigration asiatique en affirmant que le « péril jaune » submergerait la Colombie-Britannique blanche. »*[14]

En effet, bien avant l'apparition de cette « crise sociale », le gouvernement de la Colombie-Britannique avait tenté de mettre un frein à l'immigration asiatique en adoptant, en 1884, la *Chinese Immigration Act* qui imposait une taxe annuelle de 10 $ aux Chinois et aux autres Asiatiques installés en Colombie-Britannique et leur interdisait l'achat de terrains appartenant à la province. Le gouvernement fédéral désavoua cette

---

[12] Giffen, P.J. et coll., (1991) *Panic and Indifference: The Politics of Canada's Drugs Laws.* Ottawa : Centre canadien de lutte contre l'alcoolisme et les toxicomanies, p. 53.

[13] *Ibid.*, page 53.

[14] Boyd, N. (1991) *High society : Illegal and Legal Drugs in Canada.* Toronto, Key Porter Books, page 27.

loi, mais créa en 1885 la Commission royale d'enquête sur l'immigration chinoise qui a recommandé l'imposition d'un droit d'entrée de 10 $ à tout immigrant asiatique. En 1885, suite aux pressions populaires, il adopta la *Chinese Immigration Act* qui imposait un droit d'entrée de 50 $ qui fut augmenté à 500 $ en 1904, plusieurs ayant critiqué le fait que malgré le tarif imposé 20 000 Asiatiques avaient émigré au pays entre 1889 et 1900.

Un événement majeur survenu en 1907 a amené le gouvernement fédéral à intervenir dans les dossiers de l'immigration chinoise et des conflits de travail en Colombie-Britannique. Au cours de cette année, une manifestation organisée par la *Asiatic Exclusion League* rassemblant plus de 10 000 personnes, pour la plupart des travailleurs syndiqués et des gens de la classe moyenne, s'est transformée en émeute lorsque la foule en colère s'est dirigée dans le quartier chinois de Vancouver, s'attaquant aux gens et causant des dégâts matériels importants. Après avoir convaincu le Premier ministre Laurier du bien-fondé de dédommager les Chinois, William L. Mackenzie King, alors sous-ministre du Travail, est retourné à Vancouver au printemps 1908 et rédigea, à son retour, un rapport[15] qui allait mener à l'adoption de la *Loi sur l'opium*. Basé principalement sur des considérations d'ordre moral, éthique, politique, diplomatique ou ethnique, le rapport de Mackenzie King, plutôt que de s'attaquer au conflit de travail entre les travailleurs blancs et chinois, a déplacé le problème sur l'usage de l'opium par les étrangers d'origine asiatique.

> *« (l)a quantité (d'opium) qui se consomme au Canada, si elle était connue, épouvanterait la moyenne de nos concitoyens canadiens qui est portée à croire que l'habitude de l'opium se borne aux Chinois et que ceux-ci ne s'y adonne que dans une mesure restreinte. [...] il se vend presque autant d'opium aux Blancs qu'aux Chinois et [...] l'habitude de fumer de l'opium fait des progrès parmi les garçons de race blanche mais aussi parmi les femmes et les jeunes filles. »* [16]

Tout comme aux États-Unis, les immigrants chinois n'ont pas qu'apporté leur force de travail mais également la pratique de fumer de l'opium. Ils préféraient cette pratique à celle largement répandue chez les travailleurs blancs de la consommation d'alcool ou de médicaments à base d'opiacés afin de guérir une maladie ou d'oublier momentanément leurs conditions sociales ou professionnelles.[17] Ainsi, la première fumerie d'opium a ouvert ses portes à Vancouver en 1870. Certains Chinois ont même ouvert des usines fabriquant de l'opium à fumer qui était par la suite utilisé dans les fumeries du quartier chinois de Vancouver ou tout simplement vendu à la clientèle blanche. Comme l'a mentionné le professeur Boyd lors de son témoignage devant le Comité :

---

[15] William L. Mackenzie King, *Rapport sur la nécessité de supprimer le commerce de l'opium au canada*. Ottawa, Document parlementaire 36b, 1908, 18 pages

[16] *Ibid.*, pages 7-8.

[17] Beauchesne, L., (1991) *op. cit.*, page 125.

« Au fil du temps, autant d'opium à fumer était vendu aux Blancs qu'aux Chinois. On retrouve des annonces publicitaires dans les vieux numéros du "Province" de Vancouver ou du "Time Colonist" de Victoria. Aucune inquiétude ou colère ne transparaît au sujet de ces établissements d'opium à fumer, mais on trouve des annonces publicitaires. » [18]

En 1883, on dénombrait trois usines de fabrication d'opium à fumer à Victoria et, en 1891, on trouvait plus de 10 fumeries dans les quartiers chinois des grandes villes de l'Ouest canadien.[19] L'essor de cette industrie favorisait le gouvernement de la Colombie-Britannique puisque ce dernier imposait un tarif douanier sur l'opium brut de 10 % à 25 %.

« Si je pouvais nous ramener il y a une centaine d'années à Vancouver, Victoria et New Westminster, je pourrais vous montrer des établissements de consommation d'opium qui avaient ouvert leurs portes au cours des années 1870 et ont été exploités pendant une trentaine d'années sans que personne ne s'en plaigne. Ce sont des préoccupations reliées au surplus de main d'œuvre et à la dépression, pendant la première décennie du XXe siècle, qui ont été à l'origine de la première loi. Il convient de noter que la Loi sur l'opium et les drogues narcotiques de 1908 a été proposée par le ministre du Travail. Lorsqu'il a proposé la loi, il a déclaré : « nous allons pouvoir tirer parti de cette émeute » en parlant de l'émeute contre les Asiatiques qui sévissait à Vancouver en septembre 1907.
Imaginez aujourd'hui qu'un ministre du Travail propose une loi antidrogue pour essayer de tirer parti d'une crise de la main d'œuvre sur la côte ouest du Canada. C'était un peu la même chose en Californie. » [20]

Même si la Commission royale d'enquête de 1885 n'a pas recommandé de mesures spécifiques concernant la production ou l'usage d'opium à fumer, elle a tout de même indiqué que fumer une telle substance était une habitude païenne incompatible avec le mode de vie d'une nation chrétienne.[21] Selon Line Beauchesne, la croisade contre l'opium qui a succédé à ce rapport entraînera peu à peu le rejet du fumeur d'opium.[22] Les résultats d'une enquête produite par l'*American Pharmaceutical Association* en 1903 sur l'usage des drogues affirmait que la consommation de drogues était répandue dans toute la société américaine, mais plus spécifiquement au sein de deux groupes sociaux, soit les immigrés chinois et les Noirs. Cette étude a probablement eu une influence sur certains parlementaires fédéraux et les mouvements de tempérance qui ont utilisé des arguments similaires jusqu'au début des années 1930 pour justifier la prohibition de l'opium et d'autres drogues.[23]

---

[18] *Ibid.*
[19] Giffen, P.J. et coll., (1991) *op. cit.* page 125.
[20] Témoignage de Neil Boyd, professeur de criminologie, Université Simon Fraser, devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, deuxième session de la trente-sixième législature, 16 octobre 2000, fascicule 1, page 49.
[21] Beauchesne, L., *op. cit.* page 128.
[22] *Ibid.*, page 128
[23] Ati-Dion, G., (1999) *op. cit.* page 25.

En somme, bien que des considérations économiques furent au cœur du sentiment antiasiatique, les mouvements de tempérance et les groupes religieux ont tiré profit de cette situation afin de promouvoir leur discours non seulement dans la région immédiate de la Colombie-Britannique, mais également dans le reste du pays. Ces événements ont attiré l'attention de la population sur les « dangers » de l'opium pour la société canadienne.

La Loi sur l'opium de 1908

Le 10 juillet 1908, le ministre du Travail proposa à la Chambre des communes l'adoption d'une motion pour interdire : *« l'importation, la fabrication et la vente de l'opium à des fins autres que des fins médicales. »*[24] Cette motion fut adoptée sans débat. Le ministre déposa le projet de loi 205, la *Loi prohibant l'importation, la fabrication et la vente de l'opium à toutes fins autres que celles de la médecine* (Loi sur l'opium de 1908).[25] L'article premier de la loi interdisait l'importation d'opium sans autorisation du ministre des Douanes. De plus, on ne pouvait utiliser cette drogue à des fins autres que médicales. La fabrication, la vente et la possession en vue de la vente d'opium brut ou préparé à l'usage des fumeurs étaient également prohibées. Quiconque enfreignait ces dispositions pouvait être déclaré coupable d'un acte criminel passible d'une peine d'emprisonnement maximale de trois ans, d'une amende minimale de 50 $ pouvant aller jusqu'à un maximum de 1 000 $ ou de l'une de ces deux peines. Même si elle interdisait l'usage de l'opium, cette loi visait les commerçants d'opium, en majorité des Chinois, et non les simples usagers. Le projet de loi a été sanctionné le 20 juillet 1908.

Loi sur l'opium et les narcotiques de 1911

L'adoption de la *Loi sur l'opium* allait entrainer jusqu'au début des années 30 le dépôt de 8 nouvelles lois visant à la rendre à la fois plus contraignante et efficace. Le 26 janvier 1911, Mackenzie King, devenu ministre du Travail, déposa le projet de loi 97, la *Loi à l'effet de prohiber l'usage illicite de l'opium et d'autres drogues* (Loi sur l'opium et les narcotiques de 1911).[26] Lors du débat à l'étape de la deuxième lecture, Mackenzie King a invoqué trois raisons qui l'ont motivé à déposer ce texte législatif : la Commission de Shanghai, la panique suscitée à Montréal par l'usage de cocaïne et l'octroi de pouvoirs spéciaux aux policiers afin de garantir l'application efficace de loi. La Commission de Shanghai avait adopté certaines résolutions non-contraignantes incluant : mettre fin graduellement à l'habitude consistant à fumer de l'opium, en tenant compte de circonstances particulières de chaque pays; interdire l'usage de l'opium ainsi que de ses alcaloïdes ou dérivés (morphine, héroïne, etc.) et d'autres drogues à des fins

---

[24] Hansard, Chambre des communes, 10 juillet 1908, page 13182
[25] Statuts du Canada 1908, Ch. 50
[26] Statuts du Canada 1911, Ch. 17

autres que médicales; et interdire l'exportation de ces substances dans les pays qui prohibent leur usage.

Aucun député n'a soulevé d'objections quant aux quatre drogues ajoutées à l'annexe de la loi, soit la cocaïne, l'opium, la morphine ou l'eucaïne. L'article 14 de la loi prévoyait aussi que le gouverneur en conseil pouvait, par décret, ajouter à l'annexe tout alcaloïde, sous-produit ou préparation des drogues dont l'addition était jugée nécessaire dans l'intérêt public – *pouvoir que l'on retrouve encore aujourd'hui.* Ceci fut justifié en précisant que si l'usage d'une nouvelle drogue se répandait rapidement dans la société, l'ajout de cette dernière à l'annexe se ferait plus rapidement par règlement que par l'adoption d'un projet de loi.[27] D'autres dispositions de la loi concernaient l'usage de l'opium, les pouvoirs de perquisition octroyés aux policiers, les ordonnance de confiscation ou de restitution des drogues saisies ainsi que le renversement du fardeau de la preuve dans le cas d'une affaire de simple possession de drogues au détriment de l'accusé. On a aussi éliminé la possibilité de demander à un tribunal supérieur l'émission d'un bref de *certiorari* lors de poursuites intentées en vertu de ce texte législatif.

La période de l'après Première Guerre mondiale a entraîné une série de modifications importantes aux infractions, sanctions, pouvoirs policiers et procédures criminelles prévus par la *Loi sur l'opium et les narcotiques.* Plusieurs facteurs peuvent expliquer cette effervescence législative : les inquiétudes suscitées par les textes d'Emily Murphy sur l'ampleur du « fléau » de la drogue au Canada[28] ; la reprise des conflits entre les Blancs et les Asiatiques en Colombie-Britannique ; la mobilisation des associations de médecins et de pharmaciens afin d'éviter que la loi n'enfreigne leurs activités ; la création, en 1919, du ministère de la Santé et de la puissante Division des narcotiques (l'ancêtre de l'actuel Bureau sur les substances contrôlées), chargés de l'application des accords internationaux en matière de stupéfiants au Canada ; la création, en 1919, de la Gendarmerie royale du Canada (GRC), responsable de l'application de *la Loi sur l'opium et les narcotiques* ; l'adoption du *Harrison Narcotic Act* aux États-Unis en 1914 ; et la mobilisation de la communauté internationale afin d'appliquer la *Convention internationale de l'opium* (La Haye - 1912), application qui fut imposée à certains pays par le Traité de Versailles de 1919.

La création de la Division des narcotiques

L'adoption du *Harrison Narcotic Act* aux États-Unis et la mobilisation de la communauté internationale afin d'appliquer la Convention de La Haye avaient rapidement révélé trois lacunes majeures de la *Loi sur l'opium et les narcotiques* de 1911.[29]

La première difficulté est apparue au moment de contrôler les importations et les exportations de stupéfiants. La loi ne contenait qu'une vague indication concernant le

[27] Hansard, Chambre des communes, 26 janvier 1911, page 2665

[28] Nous en avons discuté au chapitre 10.

[29] Giffen, P.J., et coll., *op. cit.* page 105.

commerce de drogues à des fins médicales ou scientifiques. Dans ce contexte, les douaniers hésitaient à saisir les cargaisons d'opium ou d'autres drogues.

La deuxième difficulté provenait de l'adoption aux États-Unis du *Harrison Narcotic Act*, une loi semblable à celle adoptée au Canada en 1911. Toutefois, elle imposait un système de licences émises aux entreprises par le gouvernement fédéral qui autorisaient l'importation ou l'exportation de drogues. Cela a eu pour résultat de créer une demande importante de stupéfiants illicites aux États-Unis. Comme l'offre de ces substances au Canada excédait la demande des consommateurs, les trafiquants ont vite saisi l'occasion d'affaire et exporté leurs surplus aux États-Unis. Cette activité était devenue tellement rentable qu'en 1918, un comité du Sénat américain a déposé une plainte officielle au gouvernement canadien à propos du trafic de stupéfiants.

La troisième et dernière difficulté relevait du fait que, très tôt, les trafiquants ont pu échapper aux dispositions de la Loi de 1911 puisque son application n'était pas centralisée au sein d'un seul organisme gouvernemental. D'un côté, le ministère des Douanes tentait tant bien que mal de contrôler le commerce légal de drogues alors, que de l'autre, les services de police municipaux s'occupaient du trafic illégal, activité qui devenait toujours plus sophistiquée d'année en année, nécessitant ainsi l'octroi de nouveaux pouvoirs aux policiers.[30]

Les nombreuses modifications à loi afin de corriger ces problèmes seront, en partie, orchestrées par F. W. Cowan premier patron de la nouvelle Division des narcotiques du ministère de la Santé (1919-1927) et, surtout, par le Colonel C. H. L. Sharman, un ancien officier de la GRC son successeur (1927-1946). Cowan a vite compris après son arrivée à la tête de cette nouvelle division qu'il devait centraliser le contrôle du commerce licite et illicite de drogues pour garantir une application efficace de la loi et, par le fait même, assurer la survie à long terme de son organisation. Sous sa gouverne, un réseau imposant de communication fut créé et, à la fin des années 20, il englobait les autres directions du ministère de la Santé, le ministère de la Justice ainsi que les avocats engagés pour mener les poursuites relatives aux stupéfiants, la GRC, les médias, les services de police municipaux, les associations représentant les médecins et les pharmaciens, les gouvernements et agences d'autres pays chargées d'appliquer la loi, notamment les États-Unis, et les organismes internationaux de contrôle des stupéfiants créés par la Société des Nations.

Sous l'impulsion de Sharman, l'administration des renseignements en provenance de tous ces acteurs sera éventuellement menée uniquement par la Division, et non plus au ministère de la Justice ou à la GRC. Ainsi, le directeur pouvait avoir un portrait de l'évolution de la situation des drogues et, par le fait même, devenait un « expert » dans ce domaine. Un ancien fonctionnaire de la division a d'ailleurs qualifié le Colonel Sharman de *« tzar dirigeant son propre empire. »*[31] Son influence s'est accrue lorsque la Division fut placée sous l'autorité du sous-ministre de la Santé. Cette réorganisation a

---

[30] *Ibid.*, page 105-121.
[31] *Ibid.*, page 144.

favorisé une relation plus étroite et directe avec le ministre et les parlementaires, lui permettant ainsi de court-circuiter les propositions venant d'autres divisions du ministère. D'ailleurs, lorsque viendra le temps de proposer des nouvelles infractions, sanctions, procédures criminelles ou de nouveaux pouvoirs policiers, au cours des années 20, la Division n'hésitera pas à utiliser la « panique » provoquée par les médias à Vancouver ou les textes d'Emily Murphy pour justifier ces modifications.[32]

Du point de vue de l'application de la loi, cette structure fut très utile. Par exemple, jusqu'aux années 50, du moment qu'un policier ou un avocat, peu importe où il se trouvait au Canada, informait le directeur de la Division d'une faille dans la loi, ce dernier rédigeait des propositions d'amendements, recourait à son réseau afin de mener des consultations rapides sur les modifications proposées et, incitait, si nécessaire, le ministre de la Santé à déposer une loi afin de corriger la situation problématique. La bureaucratie fédérale des drogues, telle qu'on la connaît aujourd'hui, était née !

Dans ce contexte, la création d'un tel réseau a eu des conséquences importantes sur l'orientation de la législation canadienne sur les drogues :

> [Traduction] *« À court terme, l'établissement d'une autorité administrative [la Division] pour appliquer les lois sur les narcotiques aura comme conséquence imprévue la création d'un groupe de pression centralisé qui avait l'influence et la motivation pour jouer un rôle important dans l'évolution future de la loi. Cette centralisation des pouvoirs et de l'expertise combinée au fait que les ressources [loi, policiers, etc.] étaient dirigées vers les groupes les plus faibles de la société permet d'expliquer l'absence virtuelle de critiques efficaces ou propositions d'alternatives pour le contrôle des drogues entre 1920 et 1950. »*[33]

Les amendements à la Loi sur l'opium et les narcotiques (1920-1938)

De nombreuses modifications ont été faites à la Loi de 1911, avant qu'elle ne soit revue en profondeur en 1938. C'est au cours de cette période que le cannabis fut ajouté à l'annexe de la loi.

Modifications de la liste des substances à l'annexe : l'ajout du cannabis

De 1911 à 1938, plusieurs drogues furent ajoutées à l'annexe de la *Loi sur l'opium et les narcotiques.* La Loi de 1911 ne visait le contrôle que de quatre drogues. En 1938, lorsque la *Loi modifiant la Loi sur l'opium et des narcotiques*[34] fut adoptée, l'annexe comptait plus de 15 drogues, incluant leurs dérivés ou sels, dont le cannabis, ajouté en 1923.

Lors des travaux du Comité plénier entourant l'étude de la Loi de 1923, le ministre de la Santé, Henri-Séverin Béland, a tout simplement déclaré au sujet de cette substance: *« Il y a un nouveau narcotique dans la liste. »*[35] C'est de cette façon que le

---

[32] *Ibid.*, pages 138-146.

[33] *Ibid.*, page 127.

[34] Statuts du Canada, 1938, Ch. 9.

[35] Hansard, Chambre des communes, 23 avril 1923, page 2117.

cannabis s'est retrouvé à l'annexe de la Loi. Selon Giffen, les circonstances qui ont mené à cette décision demeurent obscures puisque, jusqu'en 1932, la question des effets du cannabis sur la santé physique, psychologique ou morale d'un individu n'avait jamais été soulevée par les parlementaires. Giffen a d'ailleurs qualifié la criminalisation de cette drogue de « solution sans problème ».

Aux États-Unis, à partir de 1890, certains médecins américains se sont inquiétés du fait que la puissance du cannabis était trop variable et que les réactions individuelles lorsqu'il était ingéré par voie orale semblaient imprévisibles. Ainsi, en dépit de la présence de drogues beaucoup plus dangereuses telles les barbituriques et les opiacés, le cannabis fut délaissé par les médecins. Au début du siècle, la découverte du caractère hallucinogène du cannabis a largement contribué à établir sa réputation comme drogue dangereuse. Toutefois, les rédacteurs du *Harrison Narcotic Act* n'avaient pas jugé nécessaire de l'assujettir aux contrôles prévus par la loi.[36] Mais, en 1915, la Californie est devenue le premier État américain à prohiber l'usage de cette drogue et au début des années 20, la marijuana *« était devenue une drogue marginale d'importance associée à l'afflux de travailleurs mexicains au sud des États-Unis dans les années 1910 et 1920. »*[37] Tout comme dans le cas de l'opium, les conflits de travail, les intérêts économiques des grandes entreprises ainsi que la moralité allaient servir de catalyseurs pour créer un mouvement populaire favorisant la prohibition du cannabis aux États-Unis, menant à l'adoption de la *Marijuana Tax Act* en 1937 qui interdisait l'usage et la production du cannabis.

Contrairement aux États-Unis, il n'existe pas de compte rendu de l'utilisation du cannabis à des fins médicales avant 1930 au Canada.[38] Et contrairement à la Californie, le Canada ne faisait pas face à une immigration de travailleurs mexicains. Qu'est-ce qui explique l'ajout du cannabis à l'annexe de la Loi sur l'opium ?

En 1922, Emily Murphy faisait référence aux effets nocifs du cannabis sur le comportement humain dans un livre intitulé *« The Black Candle »* où elle reprenait la plupart des articles qu'elle avait publiés dans le magazine *MacLean's*. Dans le chapitre intitulé : *« Marijuana – Une nouvelle menace »* elle rapportait les propos du chef de police de Los Angeles qui décrivaient les effets « terribles » du cannabis.

Mais les recherches de Giffen dans les archives du ministère de la Santé indiquent que ce discours alarmiste et fortement imprégné de moralité ne serait pas à l'origine de l'ajout du cannabis à l'annexe de la *Loi de l'opium et des narcotiques*, d'autant plus qu'à l'époque, il était à peu près inconnu au pays et sa consommation n'était pas un problème.[39] Cette affirmation est confirmée par l'article 7 de la Loi de 1932 qui modifiait une disposition de la Loi de 1920 en permettant la fabrication, la vente ou la

---

[36] Beauchesne, L., (1991) *op.cit.* page 117.

[37] Spicer, L., (2002) *Utilisations historiques et culturelles du cannabis et le débat sur la marijuana au Canada.* Ottawa : Division de la recherche parlementaire, Bibliothèque du Parlement, rapport préparé pour le Comité spécial du Sénat sur les drogues illicites, page 20. Disponible en ligne à www.parl.gc.ca/drogues-illicites.asp

[38] *Ibid.*, page 21.

[39] Giffen, P.J. et coll., *op. cit.* page 179.

distribution, sans permis, de médicaments s'ils ne contiennent que de faibles quantités de certaines drogues inscrites à l'annexe. En 1932, cette mesure pouvait désormais s'appliquer au cannabis. D'ailleurs, lors des débats parlementaires entourant l'adoption de ce texte législatif, la découverte de l'existence de cette drogue semble avoir suscité l'intérêt de certains parlementaires. Lors du Comité plénier, le député Ernest Lapointe a demandé au ministre de la Santé : *« Qu'entend-on par cannabis sativa? »* Le ministre lui a répondu : *« Jusqu'ici cette drogue n'était pas incluse dans la liste des produits qu'on pouvait employer. Je crois que c'est une forme de drogue qui s'emploie dans l'Inde et qu'on nomme communément haschisch. [...] On ne s'oppose pas à son emploi. »*[40]

En somme, il est remarquable que, plus de soixante-quinze ans plus tard, on ne sache toujours pas pourquoi le cannabis s'est retrouvé parmi les drogues prohibées. Par contre, on n'a pas manqué de « trouver des raisons » au cours des années subséquentes.

Sous l'influence des campagnes médiatiques américaines reprises par les journaux canadiens et de récits horrifiants de policiers au sujet de jeunes Canadiens physiquement et moralement détruits après avoir consommé du cannabis, le discours des parlementaires fédéraux allait en effet devenir de moins en moins tolérant envers cette drogue. La Loi de 1938, adoptée un an après l'adoption aux États-Unis du *Marijuana Tax Act*, allait marquer l'aboutissement de cette « nouvelle panique ». L'article 3 de cette loi interdisait à quiconque la culture du cannabis ou du pavot somnifère sans avoir préalablement obtenu un permis du ministère de la Santé. Les peines pour cette nouvelle infraction étaient les mêmes que celles prévues pour le trafic ou la simple possession de cannabis. Cette mesure était exceptionnelle puisque, contrairement aux autres drogues de l'annexe, la Canada jouissait, pour la première fois, de conditions climatiques favorables à la culture et la production d'une drogue sur son territoire. D'ailleurs, en analysant les débats parlementaires, on apprend que le ministère de l'Agriculture a mené des expériences scientifiques au sujet du chanvre industriel en faisant pousser du cannabis sur le territoire de la Ferme expérimentale à Ottawa et dans un autre centre de recherche, situé près de Montréal. De plus, certains entrepreneurs en Ontario cultivaient toujours le chanvre. La Loi de 1938 allait mettre fin définitivement à cette pratique.

Suite à l'introduction du projet de loi, le ministre de la Santé, Charles Power, a déclaré, au sujet de l'article 3 : *« [...] les amendements proposés se rapportent aux efforts tentés par le ministère pour contrôler ce qui constitue, non pas une nouvelle drogue, mais une menace pour la jeunesse de notre pays. »*[41] Plus loin, il a mentionné qu'il était très dangereux de fumer des cigarettes de marijuana. Afin de démontrer cette affirmation, il a cité un rapport préparé par Harry J. Anslinger, premier commissaire du *Federal Bureau of Narcotics* dans lequel il qualifiait cette drogue : *« de tueuse de jeunesse [et] qu'on doit y voir l'un des plus grands dangers pour les États-Unis. »*[42] Le ministre de la Santé déclarera néanmoins que la

[40] Hansard, Chambre des communes, 1932, page 1780.
[41] Hansard, Chambre des communes, 24 février 1938, page 793.
[42] Hansard, Chambre des communes, 24 février 1938, page 794.

situation, au Canada, n'était pas aussi grave qu'aux États-Unis. Les déclarations du ministre de la Santé sur la nocivité du cannabis ne seront contestées par aucun député et ce, même s'il n'a étayé ses propos d'aucune donnée de recherche.

Les modifications les plus importantes à l'annexe sont survenues en 1932, suite à l'adoption de la *Loi modifiant la Loi sur l'opium et les narcotiques* (Loi de 1932).[43] À cette occasion, plus de 10 substances psychoactives furent ajoutées à l'annexe, nouvelles drogues naturelles (comme la feuille de coca) ou synthétiques. L'inclusion de ces substances coïncidait avec l'adoption, en 1931, de la *Convention de Genève pour limiter la fabrication et réglementer la distribution des stupéfiants*, le Colonel Sharman, ayant largement contribué aux négociations menant à la signature de cette convention. C'est d'ailleurs à cette époque que le Canada a commencé à jouer un rôle actif sur la scène internationale en matière de drogues, appuyant les efforts des États-Unis et de Harry J. Anslinger pour mieux contrôler le commerce de stupéfiants à l'échelle internationale, notamment dans les pays producteurs.[44]

Lors du débat sur l'adoption de la Loi de 1932, loi qui devait mettre en oeuvre les dispositions de la Convention de 1931 dans le droit canadien, aucune question ne fut posée au ministre de la Santé, Murray McLaren, au sujet des raisons qui ont incité son ministère à insérer dans l'annexe les drogues précitées.

Modifications des peines

Les peines imposées pour trafic ou possession illégale de stupéfiants furent modifiées à plusieurs reprises au cours de cette période. De plus, d'autres infractions ont été créées au fur et à mesure que les techniques des trafiquants pour contourner la loi devenaient de plus en plus sophistiquées. Selon Giffen, plusieurs raisons expliquent la recherche de flexibilité par les autorités responsables de l'application de la loi :

> [Traduction] *« La flexibilité dans les peines a permis de contourner les hésitations des tribunaux à condamner sévèrement les crimes moins graves ou qui impliquaient des gens de classes sociales aisées. À cette époque, les situations de ce genre étaient fréquentes puisque la population de toxicomanes était relativement hétérogène. De plus, l'appui populaire à la loi dans les communautés locales pouvait être maintenu en évitant l'imposition de peines injustes. »*[45]

Cette flexibilité élargissait le nombre d'options offertes aux policiers et aux procureurs de la Couronne leur permettant de négocier plus facilement des plaidoyers de culpabilité, décider du type de poursuite ou d'utiliser les accusés comme informateurs ou agents d'infiltration en leur promettant une peine moindre ou le retrait des accusations. Elle permettait également, dans certains cas, l'imposition d'une peine

[43] Statuts du Canada, 1932, Ch. 20.
[44] Sinha, J. (2001) *L'historique et l'évolution des principales conventions internationales de contrôle des stupéfiants*. Ottawa : Bibliothèque du Parlement, Division de la recherche parlementaire, rapport préparé pour le Comité spécial du Sénat sur les drogues illicites, page 15. Disponible à www.parl.gc.ca/drogues-illicites.asp
[45] *Ibid.*, page 199.

minimale en réduisant la discrétion accordée au tribunal dans la détermination de la peine. L'augmentation des peines envoyait aussi un message clair aux juges sur la gravité ainsi que le niveau de réprobation sociale des crimes relatifs aux drogues. La possibilité de poursuite par procédure sommaire réduisait, quant à elle, les délais entre le moment d'une arrestation et celui de l'imposition d'une sentence. On pouvait ainsi augmenter sensiblement le nombre de condamnations. Cela était particulièrement important puisque plus le nombre de condamnations était élevé, plus la population constatait l'efficacité de la loi ainsi que l'ampleur du problème.[46]

La Loi de 1911 prévoyait une peine d'emprisonnement maximale d'un an, une amende maximale de 500 $ ou l'une de ces deux peines. En 1920, suite à la l'adoption de la *Loi modifiant la Loi sur l'opium et les narcotiques* (Loi de 1920)[47], une amende minimale de 200 $ était imposée et son maximum était augmenté à 1000 $. En 1921, la *Loi modifiant la Loi sur l'opium et les narcotiques (Loi de 1921)*[48] a modifié de façon importante la peine imposée pour ce type d'infraction. Ainsi, on créait des infractions mixtes (procédure sommaire et mise en accusation) pour ces deux activités illégales. Dans le cas d'une poursuite par mise en accusation, une peine d'emprisonnement maximale de sept ans pouvait être imposée. Dans le cas d'une déclaration de culpabilité par procédure sommaire, la peine de prison maximale était portée à 18 mois à laquelle une période additionnelle de 12 mois pour défaut de paiement d'une amende pouvait être ajoutée par le tribunal. En 1922, la *Loi modifiant la Loi sur l'opium et les narcotiques (Loi de 1922)*[49] a modifié la peine d'emprisonnement imposée pour une déclaration de culpabilité par procédure sommaire en prévoyant l'imposition d'une peine de prison minimale de six mois. En 1925, le Parlement a adopté une modification prévoyant l'imposition, à la discrétion du juge, d'une peine de travaux forcés lors d'une condamnation par procédure sommaire pour simple possession d'une drogue.

En 1921, on créa une infraction concernant la vente, le don ou la distribution de drogues par un trafiquant auprès d'un mineur. On ne pouvait poursuivre cette personne que par mise en accusation et quiconque était reconnu coupable pouvait écoper d'une peine d'emprisonnement maximale de sept ans. Suite à un débat hautement émotif, on retira la peine de fouet à l'infraction, peine qui avait été proposée par un député. Toutefois, l'année suivante, lors de l'étude de la Loi de 1922 en Comité plénier, ce même député proposa à nouveau l'imposition de la peine de fouet pour le trafiquant qui vend de la drogue à un mineur. À la fin du débat, le ministre de la Santé accepta d'ajouter la peine du fouet à la loi. Il est à noter qu'en 1929, les parlementaires fédéraux se sont prononcés sur l'élargissement de la peine de fouet aux infractions de trafic et simple possession de drogues prévue par la *Loi modifiant et codifiant la Loi sur l'opium et des narcotiques* (Loi de 1929).[50]

---

[46] *Ibid.*, pages 199-200.

[47] Statuts du Canada, 1920, Ch. 31.

[48] Statuts du Canada, 1921, Ch. 42.

[49] Statuts du Canada, 1922, Ch. 22.

[50] Statuts du Canada, Ch. 49.

Une autre peine importante fut introduite dans la Loi de 1922, la déportation des immigrants. L'article 5 de ce texte législatif, prévoyait que, nonobstant les dispositions contraires de la *Loi sur l'immigration*, tout immigrant déclaré coupable de trafic, de simple possession ou de vente de drogues à un mineur pouvait être déporté hors du Canada. De 1922 à 1944, date des dernières déportations d'immigrants pour une affaire de drogue, plus de 1 082 Chinois (82 %) furent déportés comparativement à 163 Américains (13 %) et 68 autres personnes d'origines ethniques diverses (5 %) pour un total de 1 313 déportations. En 1930, la « panique » en Colombie-Britannique était chose du passé, mais au cours des huit années précédentes, plus de 638 Chinois avaient été déportés par les autorités canadiennes.[51]

On trouve aussi d'autres infractions dans la législation à l'époque, par exemple : la possession de pipes, lampes ou tout autre équipement pour la préparation ou consommation d'opium ; le trafic de drogues par courrier ; et l'obtention de drogues en consultant deux médecins. Entre 1922 et 1930, 7096 personnes furent condamnées pour une infraction à la *Loi sur l'opium et les narcotiques.* De ce nombre, plus de 4 900 étaient des Chinois, soit une proportion de 69 %.[52]

Les pouvoirs policiers

De 1920 à 1930, grâce à plusieurs modifications à la *Loi sur l'opium et les narcotiques*, les policiers ont obtenu de nouveaux pouvoirs. Ces modifications ont porté plus particulièrement sur les pouvoirs de perquisition. L'article 7 de la Loi de 1911 prévoyait la délivrance d'un mandat de perquisition autorisant, si le policier avait des motifs raisonnables, la fouille des lieux suivants : maison d'habitation, magasin, boutique, entrepôt, jardin ou navire, et la saisie de drogues qui s'y trouvaient ainsi que les contenants dans lesquels elles avaient été découvertes. L'article 3 de la Loi de 1922 prévoyait la possibilité de mener sans mandat une fouille ou perquisition de drogues, le jour comme la nuit, dans les lieux précités. Toutefois, dans le cas d'une maison d'habitation, le policier devait obtenir un mandat.

L'article 8 de la Loi de 1911 prévoyait que les drogues saisies ainsi que les contenants dans lesquels elles avaient été trouvées pouvaient être confisqués, par le biais d'une ordonnance, au profit du tribunal et détruites après la condamnation de l'accusé. Toutefois, l'article 9 imposait certaines conditions à la procédure prévue par l'article 8. En effet, si l'accusé avait été acquitté, il disposait d'une période maximale de trois mois pour demander que le tribunal lui émette une ordonnance de restitution des drogues saisies. Si elles n'étaient pas réclamées au cours de cette période, elles devaient être détruites. La Loi de 1921 a légèrement modifié ces deux dispositions en précisant que, dorénavant, les drogues ainsi que les contenants dans lesquels elles étaient trouvées seraient confisqués au profit du ministre de la Santé qui en disposerait à sa guise. Cette modification avait été jugée nécessaire par la Division des narcotiques puisque plusieurs

[51] Giffen, P.J. et coll., *op. cit.*, page 596.
[52] *Ibid.*, page 594.

juges, plutôt que d'ordonner la destruction des ces matières, les envoyaient dans les hôpitaux. La Division craignait que les drogues ainsi retournées ne retombent entre les mains des trafiquants.

En 1923, les pouvoirs de perquisition et l'application des ordonnances de confiscation ont été étendus aux véhicules dans lesquels une drogue était trouvée. En 1929, cette procédure fut élargie à tous les véhicules de trafiquants peu importe s'il y avait eu ou non une telle substance à l'intérieur. On voulait ainsi nuire aux activités des trafiquants et éviter qu'après leur condamnation une automobile ne soit utilisée par un autre criminel. Cette procédure fut ensuite étendue aux aéronefs. En 1925, le Parlement, avec l'adoption de la *Loi modifiant la Loi sur l'opium et les narcotiques* (Loi de 1925)[53] autorisa un policier à fouiller toute personne se trouvant sur les lieux de la perquisition avec ou sans mandat.

La Loi de 1929 a accordé un pouvoir de perquisition extraordinaire aux policiers. L'article 22 de ce texte législatif permettait l'émission à un policier d'un mandat de main-forte. Il s'agissait d'un pouvoir général, sans restriction de temps ni de lieu, qui demeurait valide pendant toute la carrière de l'agent de la paix. Ce mandat autorisait son récipiendaire à entrer à toute heure, avec l'aide des personnes qu'il estimait nécessaires, dans une maison d'habitation pour y faire des fouilles et saisir des drogues. Le mandat de main-forte permettait ainsi de contourner l'interdiction de fouiller ou saisir des drogues dans une maison d'habitation sans mandat. Au même moment, la loi fut également amendée afin d'autoriser les policiers lors de fouilles ou saisies avec ou sans mandat de recourir, si nécessaire, à la force pour réaliser une perquisition et d'être assistés par d'autres personnes que des agents de la paix.

[53] Statuts du Canada, 1925, Ch. 20.

La procédure criminelle

Au cours des années 20, une autre modification importante aura pour but de faciliter les condamnations dans les poursuites impliquant des stupéfiants : le renversement du fardeau de la preuve au détriment de l'accusé. C'est dorénavant à ce dernier, et non plus au procureur de la Couronne, qu'il appartient de prouver qu'il n'a pas commis le crime pour lequel il est accusé. En droit pénal britannique, la tâche de prouver la culpabilité d'un accusé revient traditionnellement à la Couronne, d'où l'origine de l'expression : « présumé innocent jusqu'à preuve du contraire ».

L'article 10 de la Loi de 1911 prévoyait que, dans le cas d'une poursuite pour simple possession ou trafic de drogues (à l'exception de l'importation et l'exportation), l'accusé devait prouver soit l'existence d'une excuse légitime, soit l'utilisation de telles substances à des fins thérapeutiques ou scientifiques pour être acquitté. Lorsqu'en 1920, le Parlement a modifié la *Loi sur l'opium et les narcotiques* afin de mieux encadrer les importations et les exportations, la fabrication, la vente et la prescription par les médecins des drogues inscrites à l'annexe par le biais d'un permis, la procédure établie en 1911 fut modifiée afin de spécifier que l'accusé devait prouver qu'il disposait d'un permis dûment émis par le ministère de la Santé pour être acquitté.

Or, l'article premier de la Loi de 1921 a élargi l'application du renversement du fardeau de la preuve à toute personne qui possédait ou occupait un endroit (logement, magasin, boutique, entrepôt, jardin ou navire) où une drogue avait été trouvée. Selon le libellé de l'article, elle était réputée posséder une telle substance si elle était incapable de prouver qu'elle était à cet endroit sans son consentement ou ignorait que la drogue s'y trouvait.

L'article prévoyait également l'application de cette procédure lorsqu'une personne était accusée de trafic d'opium brut ou préparé pour l'usage des fumeurs sans avoir préalablement obtenu un permis émis par les autorités fédérales. En 1923, la *Loi à l'effet de prohiber l'usage illicite de l'opium et autres drogues* (Loi de 1923)[54] a étendu l'application de la procédure de renversement du fardeau de la preuve aux infractions relatives à l'exportation ou l'importation d'une drogue sans permis. Dans les cas impliquant la prescription ou l'administration à des fins non-thérapeutiques d'une substance inscrite à l'annexe, un médecin ou un pharmacien devait prouver que cette substance avait été uniquement utilisée à des fins médicales.

La Loi de 1923 a annulé une autre garantie juridique fondamentale : le droit d'appel. En effet, l'article 25 annulait le droit d'appel dans le cas d'une déclaration de culpabilité par procédure sommaire dans les cas de simple possession, de trafic de drogues sans permis ou lors de la vente, du don ou de la distribution d'une drogue à un mineur, une infraction qui était pourtant uniquement punissable par voie de mise en accusation ! L'article 26 de la Loi de 1929 a élargi cette procédure à la possession ou au trafic d'une substance qui *s'apparente* à une drogue. Cette nouvelle procédure rendait

[54] Statuts du Canada, Ch. 22.

caduque la disposition adoptée en 1911 interdisant toute demande de bref de *certiorari* et la Division des narcotiques a jugé bon de la retirer de la loi, ce qui fut fait en 1929.[55]

Deux autres modifications importantes furent apportées à la *Loi sur l'opium et les narcotiques* entre 1920 et 1930 : l'admissibilité du certificat d'un analyste fédéral et l'application des dispositions de la *Loi sur l'identification des criminels* suite à une déclaration de culpabilité par procédure sommaire. L'article premier de la Loi de 1921 avait modifié la procédure judiciaire applicable en matière de poursuites relatives aux drogues en permettant l'admissibilité du certificat d'un analyste fédéral en preuve relativement à une ou plusieurs drogues saisies par les policiers. Les tribunaux, cependant, hésitaient à accepter le certificat parce qu'ils étaient incapables d'authentifier la signature de l'analyste[56] ou de confirmer sa nomination. En 1929, un amendement fut apporté à la *Loi sur l'opium et les narcotiques* (article 18) précisant que, dorénavant, le certificat constituait une preuve *prima facie* et péremptoire du statut de la personne qui le donnait ou l'émettait. Dans ce contexte, la preuve de la nomination de cette personne ou l'authentification de sa signature n'était plus nécessaire.

En 1923, la *Loi sur l'opium et les narcotiques* fut amendée pour que s'appliquent aux personnes condamnées suite à une déclaration de culpabilité par procédure sommaire les dispositions de la *Loi sur l'identification des criminels.* L'article 2 de cette loi autorisait la prise des empreintes digitales, des photographies ainsi que des mensurations par un policier uniquement dans le cas de poursuites par voie de mise en accusation. Ces renseignements constituent le « casier judiciaire » officiel d'un individu qui est conservé dans les fichiers nationaux de la police avec toutes les conséquences que cela implique en matière de stigmatisation sociale, professionnelle ou familiale. Or, du point de vue de la Division des narcotiques, cette modification était avantageuse puisqu'elle permettrait dorénavant d'établir des dossiers et de mieux surveiller les toxicomanes condamnés par procédure sommaire.

Les mesures de contrôle

La *Loi modifiant la Loi de l'opium et des drogues narcotiques* (Loi de 1920)[57] établissait un régime de contrôle du commerce légal de stupéfiants via un système de permis qui étaient émis aux entreprises, pharmaciens ou médecins par le ministère de la Santé le tout dans le but de mieux encadrer l'approvisionnement du Canada en drogues pour des fins médicales ou scientifiques. Ainsi, la Loi prévoyait : l'interdiction d'importer ou d'exporter des drogues dans un port non-désigné à cette fin par les autorités fédérales ; l'émission de permis pour l'importation, l'exportation, la fabrication, la vente et la distribution de drogues ; l'imposition de critères concernant l'emballage et l'étiquetage de paquets contenant de telles substances ; l'obligation pour une entreprise de tenir un registre sur ses activités d'importation, d'exportation, de fabrication, de vente et de distribution de stupéfiants dûment autorisées par les autorités fédérales ; l'obligation

---

[55] Giffen, P.J. et coll., *op. cit.*, page 261.

[56] *Ibid.*, pages 278-279.

[57] Statuts du Canada, 1920, Ch. 31.

pour les médecins de fournir les renseignements demandés par les autorités fédérales relativement à l'achat, la fabrication ou la prescription de médicaments contenant des drogues ; l'obligation pour un pharmacien de tenir un registre concernant ses achats ou ventes de drogues, la fabrication de ses propres médicaments contenant de telles substances et le renouvellement des ordonnances signées par un médecin[58] ; et l'autorisation de vendre des médicaments (tels les onguents ou liniments) contenant de très faibles quantités de drogues inscrites à l'annexe de la loi, sans permis, à condition qu'ils ne soient pas administrés à des enfants de moins de deux ans et qu'ils respectent certains critères d'étiquetage.

Les modifications à la Loi sur l'opium et les narcotiques en 1954

En 1954, le Parlement fédéral a adopté la *Loi modifiant la Loi sur l'opium et les narcotiques* (Loi de 1954)[59] Cette loi abrogeait les infractions relatives à l'usage d'opium ou la possession d'équipements destinés à cette fin, la vente de drogues à un mineur et le trafic de stupéfiants par courrier. Elle apportait également deux autres modifications importantes à la loi.

Sous l'impulsion de R. E. Curran, sous-ministre de la Santé, elle comprenait maintenant une définition de l'infraction de trafic de stupéfiants afin de rendre la loi plus compréhensible et augmentait la durée de la période d'emprisonnement maximal qui s'y rattachait de sept à quatorze ans. La peine minimale d'emprisonnement de six mois ainsi que l'amende furent abrogés. Désormais, cette infraction ne pouvait être poursuivie que par voie de mise en accusation seulement. Ce crime était par contre toujours passible du fouet et de la déportation.[60]

Le paragraphe 4(3) de la Loi de 1954 créait une infraction de possession en vue de trafic à laquelle les nouvelles peines prévues pour le trafic de stupéfiant s'appliquaient. Cette nouvelle infraction ferait en sorte que les détenteurs d'importantes quantités de stupéfiants ne puissent plus être condamnés pour simple possession. Comme nous l'avons vu plus tôt, de 1911 à 1929 un renversement du fardeau de la preuve s'était opéré dans la législation canadienne en matière de drogues. En 1954, le paragraphe 4(4) ajouta une nouvelle procédure pénale afin de faciliter les condamnations pour possession de stupéfiants à des fins de trafic.

---

[58] Cette disposition fut ajoutée à la Loi de 1911. Au cours des années qui vont suivre, les critères concernant le renouvellement de prescriptions émises par des médecins furent restreints afin de mieux contrôler le commerce légal des stupéfiants et éviter que des toxicomanes obtiennent des ordonnances et utilisent les drogues ainsi obtenues à des fins de trafic. Par exemple, la Loi de 1921 précisa qu'un pharmacien ne pouvait remplir ou renouveler une prescription que si elle avait été signée par un médecin. La Loi de 1923 allait plus loin en interdisant le renouvellement à plusieurs reprises d'une drogue à partir de la prescription d'origine. Le patient devait donc consulter un médecin à chaque fois qu'il voulait la renouveler.

[59] Statuts du Canada, 1954, Ch. 38.

[60] Les dispositions concernant la déportation des immigrants furent transférées à la *Loi sur l'immigration* en 1952, mais s'appliquaient toujours aux infractions liées aux drogues.

Ainsi, dans toute poursuite criminelle impliquant cette infraction, le procureur de la Couronne devait d'abord prouver que l'accusé était illégalement en possession de la drogue. L'intimé devait alors prouver qu'il ne possédait pas cette substance à des fins de trafic. S'il réussissait sa démarche, il était trouvé coupable de simple possession, sinon, il était condamné pour trafic. Les tribunaux canadiens, dans ce cas précis, ont établi une distinction entre le fardeau dit secondaire qui consiste à fournir la preuve d'un fait particulier (en l'occurrence le fait de prouver l'intention de trafic) et le fardeau primaire (la possession illégale) qui consiste à prouver ce fait lorsque tous les éléments de preuve sont réunis. Ainsi, c'est toujours au procureur de la Couronne que revient le fardeau primaire d'établir qu'il y a bel et bien eu acte criminel. Mais, dans le cas qui nous intéresse, la Couronne n'a pas à prouver l'intention de l'accusé en matière de trafic. La preuve de possession illégale suffisait au tribunal pour conclure à l'intention de trafic.

L'adoption de cette modification faisait suite à une recommandation de la GRC et du Bureau des stupéfiants (anciennement Division des narcotiques) puisqu'à défaut d'un aveu de l'accusé, il était très difficile de prouver l'intention de trafic. Or, cette nouvelle procédure affaiblissait considérablement les droits de l'accusé, surtout que la loi ne précisait pas la quantité de stupéfiants nécessaire à déterminer s'il s'agissait vraiment de possession en vue de trafic. Tout compte fait, l'accusé était désormais coupable, jusqu'à preuve du contraire.[61]

Le rapport du Sénat de 1955

Eh oui ! Nous avions un prédécesseur. Le 24 février 1955, le Sénat a adopté une motion prévoyant la création d'un Comité spécial sur le trafic de stupéfiants au Canada suivant la proposition faite, quelques semaines plus tôt, par le sénateur Thomas Reid. À cette occasion, ce dernier avait demandé au Leader du gouvernement au Sénat, W. Ross MacDonald, si le gouvernement fédéral avait l'intention de créer un tel comité puisque, selon ses informations, dans la ville de Vancouver, le trafic de l'opium et d'autres stupéfiants échappait au contrôle des autorités policières. Au cours du débat sur la motion, le sénateur MacDonald a bien résumé la tâche qui attendait les membres de la commission sénatoriale spéciale:

> *« Le travail du comité consistera surtout à étudier les causes de ce problème tragique [le trafic de stupéfiants] auquel doit faire face notre pays, à entendre des témoignages de spécialistes en la matière et à établir la façon dont le gouvernement peut le mieux contribuer à résoudre cette triste situation. Le rapport du comité, fondé sur une appréciation objective, prudente et réaliste du problème, peut fort bien devenir un document de la plus grande importance qui influera en fin de compte sur la ligne de conduite à suivre pour résoudre efficacement cette question. »*[62]

[61] Giffen, P.J. et coll., *op. cit.*, pages 448-450.
[62] Hansard, Sénat, 24 février 1955, page 239.

Suite à l'adoption de la motion, le sénateur Reid fut nommé président du Comité. Du 15 mars au 17 juin 1955, le Comité a organisé des audiences publiques à Ottawa et fut le premier à voyager à l'extérieur de la capitale fédérale en organisant des séances à Montréal, Toronto et Vancouver. Les sénateurs ont également rencontré, en plus des spécialistes, fonctionnaires et policiers, un groupe de 150 toxicomanes à la prison d'Oakalla à Vancouver afin de mieux comprendre les raisons qui les incitaient à consommer des stupéfiants. Le Comité a entendu 52 témoins dont 13 provenaient d'organisations chargées d'appliquer la loi, 10 œuvraient au sein des différents ministères fédéraux concernés par la lutte au trafic de stupéfiants et 12 étaient spécialisés dans le traitement des toxicomanes. Le 23 juin 1955, le sénateur Reid a déposé le rapport du Comité contenant une série de recommandations visant le traitement des toxicomanes et la lutte au trafic de stupéfiants.

Selon le rapport, les chiffres fournis par le ministère de la Santé révélaient qu'il y avait au Canada 515 « toxicomanes malades », c'est-à-dire devenus dépendants à une drogue suite au traitement d'une maladie, 333 « toxicomanes professionnels » (médecins, pharmaciens, etc.) et 2 364 « toxicomanes criminels », soit un total de 3 212. Des personnes appartenant à cette dernière catégorie, 1 101 résidaient à Vancouver.[63] Seulement 26 des 2 364 « toxicomanes » criminels étaient âgés de moins de 20 ans!

Pour établir un lien entre la criminalité et la toxicomanie et expliquer les difficultés d'établir des programmes de traitement, le Comité a cité une étude réalisée par la GRC mentionnant que sur 2009 toxicomanes criminels, 341 avaient d'abord été déclarés coupables d'une première infraction à la *Loi sur l'opium et les narcotiques*, 1 220 avaient d'abord été condamnés pour d'autres crimes et les 478 autres avaient déjà un casier judiciaire. La GRC en concluait que vraisemblablement 1 668 toxicomanes sur un total de 2 009 étaient des criminels, ce qui fut suffisant aux yeux des membres du Comité pour confirmer la thèse de l'usager «criminel » ou «contaminateur ».[64] Même si les calculs et les déductions de la GRC étaient nébuleux, il devenait par contre « clair » pour les sénateurs que la toxicomanie n'était pas une maladie.

Selon le comité, la plupart des toxicomanes provenaient de milieux défavorisés où la criminalité et les problèmes familiaux étaient omniprésents :

> *« Les témoignages des médecins rapportaient que la toxicomanie ne constitue pas une maladie proprement dite. C'est un symptôme d'une faiblesse du caractère et des défauts de la personnalité de la victime. Le toxicomane est d'ordinaire une personne émotivement déséquilibrée et instable à laquelle les stupéfiants donnent du "cran". Le Comité a appris avec consternation qu'on avait pu établir avec certitude dans relativement peu de cas que des toxicomanes, pendant qu'ils étaient en liberté, avaient réussi à se passer de drogues pour une période prolongée. Les complications et les difficultés que présente le traitement de la toxicomanie eu égard aux habitudes du toxicomane et à ses tendances criminelles presque invariables ne sauraient être trop fortement soulignées. »*[65]

---

[63] Hansard, Sénat, 23 juin 1955, page 739.
[64] Hansard, Sénat, 23 juin 1955, page 739.
[65] Hansard, Sénat, 23 juin 1955, page 742.

Dans ce contexte, le Comité a rejeté à l'unanimité la création de cliniques gouvernementales qui fourniraient, moyennant certaines conditions, des cures d'entretien aux « toxicomanes criminels ». Le rapport soulignait d'ailleurs qu'une résolution adoptée, à l'époque, lors de la 10e session annuelle de la Commission des stupéfiants des Nations-Unies, indiquait que cette forme de traitement n'était pas à conseiller.[66] Il a également rejeté l'application du modèle du Royaume-Uni après avoir confirmé, à l'aide de spécialistes britanniques, que les médecins ne devaient pas encourager un toxicomane à persister dans sa toxicomanie s'il ne pouvait pas s'abstenir de consommer des stupéfiants, même après un long traitement impliquant la réduction graduelle des doses prescrites. À cet égard, le rapport mentionne : *« [...] les drogues dangereuses sont assujetties au Royaume-Uni dans une large mesure à la surveillance qu'exigent les normes sévères des accords internationaux auxquels le Royaume-Uni, de même que le Canada, sont parties. »*[67]

Puisque les « toxicomanes » sont *« à l'origine des criminels, se livrant quotidiennement à des délits outre leurs violations de la Loi sur l'opium et les narcotiques »*, les autorités municipales et policières, plus particulièrement celles de Vancouver, devraient appliquer plus rigoureusement les dispositions du *Code criminel* concernant le vol, le vagabondage ainsi que la prostitution. Citant un témoignage de Harry J. Anslinger devant un comité du Congrès américain, le rapport indiquait qu'une telle initiative réglerait une bonne partie du problème causé par la toxicomanie. Dans un deuxième temps, le rapport notait que : *« les dépositions de beaucoup de témoins ont recommandé la ségrégation et l'isolement de tous les toxicomanes pendant de longues périodes aux fins de traitements et de guérison. »*[68]

Ainsi, afin d'éviter la propagation de ce « fléau » dans les pénitenciers et guérir les toxicomanes criminels condamnés pour un crime quelconque, le rapport proposait : *« que les autorités des pénitenciers approfondissent les problèmes particuliers de la toxicomanie en vue de les isoler et leur imposer un traitement comprenant une formation spécialisée, une rééducation et autres mesures nécessaires à la solution des problèmes particuliers que l'usage des stupéfiants complique. »* [69] À vrai dire, tout comme l'avait fait le ministre de la Santé, Paul Martin, un an auparavant, le Comité a plutôt insisté sur les limites de la compétence fédérale et sur les efforts que les provinces devraient consacrer au traitement des toxicomanes qui n'avaient pas été condamnés pour un crime. Préconisant toujours l'isolement de ces personnes, le rapport indiquait que le gouvernement fédéral voulait mettre à la disposition de la Colombie-Britannique la station fédérale de quarantaine de William-Head, dans l'Île-de-Vancouver, pour qu'elle puisse la transformer en centre de traitement, semblable à celui qui existait à Lexington, dans l'État du Kentucky, aux États-Unis. De plus, il proposait la création d'un programme national de santé afin d'appuyer financièrement les initiatives provinciales en matière de toxicomanie.

---

[66] Hansard, Sénat, 23 juin 1955, page 740.
[67] Hansard, Sénat, 23 juin 1955, page 740.
[68] Hansard, Sénat, 23 juin 1955, page 744.
[69] Hansard, Sénat, 23 juin 1955, page 745.

Le Comité a également encouragé la création de groupes semblables aux Alcooliques anonymes. Par contre, il a rejeté la création de campagnes nationales d'éducation auprès de la population et des adolescents sous prétexte : *« que de tels programmes ne devraient pas être utilisés s'ils peuvent éveiller une curiosité indue chez les jeunes. »*[70] Le Comité a jugé bon d'appuyer la position prise par la Commission des stupéfiants des Nations Unies recommandant plutôt la création d'un programme « d'hygiène mentale » visant à détecter dans les écoles les comportements pouvant mener à la toxicomanie.

Puisque les programmes de traitement ne pouvaient pas guérir tous les toxicomanes, le Comité a aussi proposé l'adoption de certaines mesures pour mieux combattre le trafic illicite de stupéfiants. Ainsi, il recommandait :

- La création d'une infraction distincte concernant l'importation ou l'exportation illicite de stupéfiants afin de mettre fin à la contrebande ;
- L'imposition d'une peine minimale d'emprisonnement pouvant aller jusqu'à un maximum de 25 ans (perpétuité) pour cette nouvelle infraction ;
- L'augmentation de la peine d'emprisonnement maximale de 14 à 25 ans pour les infractions de trafic ; et
- La possibilité d'établir une preuve de complot afin de faciliter la condamnation des dirigeants d'organisations criminelles qui ne sont pas directement impliqués dans la vente de stupéfiants mais qui en retirent les bénéfices (le fameux « patron »).

Selon le Comité, la sévérité de ces peines aurait : « *un effet préventif pour un grand nombre de toxicomanes qui pourraient être tentés d'aider à la distribution des stupéfiants; et qu'en les empêchant de se faire distributeurs de drogues, on fera en sorte que le « patron » ait plus de difficultés à écouler ces produits.* »[71] Plutôt que des gaspiller de précieuses ressources policières et judiciaires pour faire condamner les têtes dirigeantes du crime organisé qui étaient à l'origine du problème, il fallait éliminer les « trafiquants-toxicomanes » des quartiers des grandes villes et le problème serait réglé.

Même si les propositions du Comité furent beaucoup plus conservatrices que celles proposées au cours des débats qui avaient précédé sa formation, la plupart de ses recommandations seront suivies par les autorités fédérales. Dans un premier temps, il a contribué à la réalisation, en 1956, de plusieurs projets de recherche en Colombie-Britannique et en Ontario. Dans un deuxième temps, le rapport du Comité du Sénat fut à l'origine de la plupart des nouvelles dispositions de la *Loi sur les stupéfiants*, adoptée en 1961, qui allait remplacer la *Loi sur l'opium et les narcotiques.*

DE 1960 À LA COMMISSION LE DAIN : À LA RECHERCHE DES RAISONS PERDUES

[70] Hansard, Sénat, 23 juin 1955, page 741.
[71] Hansard, Sénat, 23 juin 1955, page 746.

La période suivant la Deuxième Guerre voit l'arrivée de nouveaux discours en matière de contrôle des stupéfiants qui remettront en question l'approche adoptée par le Canada depuis 1908 pour lutter contre l'abus et le trafic de stupéfiants. Ainsi, le mouvement international en faveur du respect des droits de l'homme, la création d'organismes voués à la défense des libertés civiles, la démocratisation graduelle de l'accès aux études universitaires, l'apparition et le développement de nouvelles disciplines appartenant au domaine des sciences sociales telles la criminologie, la psychologie, la sociologie, la science politique ou la sociologie du droit, les progrès scientifiques et les recherches en matière de toxicomanie ont contribué à créer de nouveaux groupes de pression formés de personnes plus articulées qui contestent l'utilisation du droit pénal comme solution « miracle » pour traiter les problèmes des drogues. Mais il faudra attendre l'explosion de la consommation de drogues des années 1960, le mouvement de contestation hippie et les travaux de la Commission Le Dain, avant de voir se matérialiser ces revendications.

La Loi sur les stupéfiants (1961)

L'adoption de la *Loi sur les stupéfiants* (Loi de 1961)[72] a coïncidé avec l'entrée en vigueur de la *Convention unique sur les stupéfiants* de 1961. Cette dernière a joué un rôle important dans la création du système moderne de contrôle international des stupéfiants. Il s'agissait d'un prolongement et d'un élargissement de l'infrastructure juridique internationale élaborée entre 1909 et 1953. Les travaux visant le regroupement des neuf traités multilatéraux adoptés au cours de cette période en un seul texte international ont débuté en 1948 et le Canada a joué un rôle important dans la rédaction et les négociations qui ont mené à son adoption.

Même si la loi conserve la plupart des procédures criminelles ainsi que les infractions établies au cours des années précédentes, deux modifications feront l'objet de débats parlementaires importants : la création d'une infraction pour l'importation ou l'exportation illégale de stupéfiants et l'augmentation des peines pour l'infraction de trafic, et le traitement des toxicomanes. Seront abrogées la peine d'emprisonnement minimal de six mois imposée lors d'une infraction pour simple possession, la procédure prévoyant l'application de la *Loi sur l'identification des criminels* dans le cas d'une déclaration de culpabilité par procédure sommaire ainsi que celle annulant le droit d'appel pour certaines infractions.

La Loi de 1961 était divisée en deux parties : la première, intitulée « Infractions et exécution de la Loi », placée sous l'autorité du ministre de la Santé, et la deuxième, « Détention préventive et détention aux fins de traitement », administrée par le ministre de la Justice.

L'article 5 de la Loi de 1961, créait, comme l'avait recommandé le Comité du Sénat, l'infraction d'importation et d'exportation de stupéfiants. Quiconque en était

[72] Statuts du Canada, 1961, Ch. 35.

reconnu coupable (par voie de mise en accusation seulement) était passible d'une peine minimale d'emprisonnement de sept ans jusqu'à un maximum de 25 ans. Cette disposition visait à combattre la contrebande de stupéfiants entre les États-Unis et le Canada ainsi qu'à respecter les engagements internationaux contractés par le Canada en ratifiant la Convention unique.[73]

L'article 4 de la Loi de 1961 portait de 14 à 25 ans, comme le recommandait aussi le rapport du Comité du Sénat, la peine d'emprisonnement maximale pour le trafic de stupéfiants. Le recours au fouet est éliminé. Ces modifications s'appliqueront aussi à la peine prévue pour possession en vue de trafic.

La Partie II de la loi (articles 15 à 19) définissait la nouvelle politique fédérale en matière de détention préventive ou de traitement. Dans un premier temps, le tribunal pouvait dorénavant ordonner, après une infraction de trafic, de possession en vue de trafic ou d'exportation ou importation de drogues et seulement si l'accusé avait déjà été condamné pour des infractions semblables, que ce dernier soit placé en détention préventive pour une période indéterminée. Cette mesure remplaçait toute autre sentence qui avait pu lui être imposée. Dans un deuxième temps, lorsqu'une personne était accusée pour une infraction de possession simple, de possession en vue de trafic, de trafic, ou d'exportation ou d'importation, le tribunal, sur demande du procureur de la Couronne ou de l'accusé, pouvait renvoyer ce dernier en détention pour examen afin de déterminer s'il était admissible à un programme de traitement pour toxicomanie. Si tel était le cas, l'accusé devait être condamné à la détention aux fins de traitement dans une institution fédérale spécialisée pour une période indéterminée au lieu de toute autre sentence prévue par la loi. Dans le cas d'une première infraction, la détention préventive ne pouvait excéder 10 ans. La personne disposait d'un droit d'appel, était assujettie à la *Loi sur les libérations conditionnelles* et, à tout moment, pouvait être renvoyée en détention préventive si elle avait fait usage de drogues au cours de sa période de probation.

Enfin, la Loi de 1961 prévoyait que, si une province adoptait une politique de détention préventive accompagnée d'un programme de traitement pour toxicomanie (dans les cas qui n'impliquent pas une infraction à la loi), le gouvernement fédéral pouvait conclure une entente avec les autorités compétentes de cette province afin de transférer les toxicomanes dans les institutions fédérales spécialisées. Ces nouvelles dispositions reprenaient en fait les propositions du Comité du Sénat.

Malgré l'intervention de deux ministres, cette politique de traitement, ayant toujours en trame une approche pénale et orientée jusqu'à un certain point vers la répression de *« l'usager contaminateur »* ou *« l'usager criminel »*, n'a pas suscité l'intérêt des parlementaires. Ces mesures furent adoptées sans opposition mais, pour des raisons obscures, ne furent jamais proclamées. La Commission Le Dain s'est d'ailleurs interrogée sur cette décision du gouvernement fédéral : *« Peut-être a-t-on eu des doutes sur la constitutionnalité de ces dispositions, ou a-t-on négligé de mettre au point les méthodes de traitement et*

---

[73] Hansard, Chambre des communes, 7 juin 1961, page 6794.

les établissements nécessaires, ou encore le gouvernement s'est-il interrogé sur l'opportunité de la cure obligatoire. »[74]

Une autre disposition de la Loi de 1961, et non la moindre, fut adoptée par le Parlement sans débat. Il s'agit de l'annexe. La Convention unique de 1961 contenait une série d'annexes établies par l'Organisation mondiale de la santé comportant la liste des drogues soumises à un contrôle rigoureux afin d'éviter qu'elles ne soient utilisées à des fins autres que médicales ou scientifiques. La majorité d'entre elles se retrouvaient à l'annexe de la Loi de 1961 qui, désormais, comptait plus de 92 drogues ou leurs dérivés répartis dans 14 grandes catégories (opium, cannabis, coca, phénypipédridine, etc.). Aucun député n'a questionné le ministre de la Santé afin de déterminer les critères ou les raisons invoquées par son ministère afin d'assujettir un nombre aussi important de substances aux dispositions contraignantes de la loi.

La Loi sur les aliments et drogues et les barbituriques (1961)

Au début des années 60, la consommation de drogues qui n'étaient pas incluses dans l'annexe de la *Loi sur l'opium et les narcotiques* ou, plus tard, dans la *Loi sur les stupéfiants* a commencé à inquiéter les autorités médicales et gouvernementales. Il s'agissait des acides barbituriques ou « goof balls », des amphétamines, des méthamphétamines ainsi que les sels et dérivés de ces trois substances. Tombant dans la catégorie des drogues dites psychotropes, elles peuvent être utilisées pour réduire le stress, éliminer l'insomnie, stimuler l'activité musculaire et cérébrale ou éliminer l'appétit.

Or, lorsque les médecins et autres professionnels de la santé ont commencé à recenser au cours des années 50 plusieurs cas de dépendance aux barbituriques et l'existence de graves effets secondaires, ils ont demandé au gouvernement de mieux réglementer leur distribution et leur usage. De plus, en 1957, suivant une enquête du ministère de la Santé auprès de 2500 pharmacies, plus de 300 condamnations furent prononcées contre des pharmaciens qui n'avaient pas respecté les règlements concernant la prescription de barbituriques ou d'amphétamines. Cette fois, il convient de le signaler, le discours des professionnels de la santé a davantage influencé les autorités gouvernementales que celui des policiers ou celui du Bureau des stupéfiants. Deux facteurs furent à l'origine de l'inclusion de ces substances dans la *Loi sur les aliments et drogues* sous l'appellation de «drogues contrôlées » et non de la *Loi sur les stupéfiants.* Dans un premier temps, certaines dispositions sévères de la Loi de 1961 étaient de plus en plus critiquées. Dans un deuxième temps, l'utilisation de ces substances dans plusieurs médicaments vendus sous prescription faisait en sorte que leur usage était très répandu dans la population, notamment chez les personnes occupant de bons emplois, ce qui, en fin de compte, était bien différent du portrait peu

---

[74] Le Dain, G., et coll., (1972) *Le cannabis : rapport de la Commission d'enquête sur l'usage des drogues à des fins non-médicales*. Ottawa, Gouvernement du Canada, pages 222-223.

élogieux du toxicomane dressé jusqu'alors. Dans ce contexte, le recours aux dispositions de la Loi de 1961 était à proscrire.[75]

En 1961, le Parlement a donc adopté la *Loi modifiant la Loi sur les aliments et drogues* (Loi sur les aliments et drogues de 1961)[76] afin de mieux réglementer le commerce de barbituriques et des amphétamines. La nouvelle loi créait la Partie III concernant les « drogues contrôlées » inscrites à l'annexe G. Elle créait une infraction de trafic ou de possession en vue de trafic passible, par mise en accusation, d'un emprisonnement maximal de 10 ans et, par procédure sommaire, d'une peine de prison maximale de 18 mois. Toutefois, la simple possession de ces substances n'était pas illégale. De plus, contrairement à la *Loi sur les stupéfiants*, la définition de trafic excluait la distribution ou le don d'une drogue contrôlée mais englobait les infractions d'importation et d'exportation.

Dans le cas des procédures criminelles applicables lors d'un procès, elles reprenaient plusieurs éléments de la Loi de 1961 tels la procédure concernant le renversement du fardeau de la preuve dans une poursuite pour possession à des fins de trafic, le recours à un certificat d'un analyste fédéral pour confirmer la nature de la drogue, les pouvoirs de perquisition et de saisie, la délivrance d'un mandat de main-forte, la restitution des substances saisies et la confiscation de ces dernières.

Enfin, l'annexe G de la loi comportait trois drogues soit les amphétamines, les acides barbituriques, les méthamphétamines ainsi que les sels ou dérivés de ces dernières. Pendant les débats, un député a demandé pourquoi d'autres substances du même type n'étaient pas incluses dans l'annexe. Le ministre de la Santé a répondu que selon les recherches scientifiques, seulement ces trois drogues étaient considérées dangereuses pour la santé humaine.[77] De plus, tout comme dans l'ancienne *Loi sur l'opium et les narcotiques* et la nouvelle *Loi sur les stupéfiants*, le gouverneur en conseil pouvait adopter des règlements sur recommandation du ministre de la Santé et si l'intérêt public le justifiait afin de modifier l'annexe.[78]

<u>La *Loi sur les aliments et drogues* et les hallucinogènes (1969)</u>

En 1969, le Parlement a étendu l'application des contrôles législatifs et bureaucratiques aux drogues hallucinogènes en adoptant la *Loi modifiant la Loi sur les aliments et drogues* (Loi sur les aliments et drogues de 1969).[79] Ce texte législatif créait la Partie IV qui devait régir l'usage et le commerce des drogues à «usage restreint » énumérées à la nouvelle annexe J. On y retrouvait la diéthylamide de l'acide lysergique (LSD), la N-Diéthyltryptamine (DET) ou la Méthyl-2,5-diméthoxyamphétamine (STP).

Afin de mieux contrôler l'usage et le commerce des drogues hallucinogènes, cette loi comprenait les mêmes infractions et procédures que celles s'appliquant aux

[75] Giffen, P.J. et coll., *op. cit.*, pages 471-475.

[76] Statuts du Canada, 1961, Ch. 37.

[77] Hansard, Chambre des communes, 30 mai 1961, page 5799.

[78] Paragraphe 37(2) de la *Loi sur les aliments et drogues de 1961*.

[79] Statuts du Canada, Ch. 41.

barbituriques. Elle créait également une infraction de simple possession afin de dissuader une personne de faire usage d'une telle drogue, passible, par voie de mise en accusation, d'une peine d'emprisonnement maximale de trois ans ou d'une amende de 5 000 $.[80] Dans le cas d'une condamnation suite à une déclaration de culpabilité par procédure sommaire, s'agissant d'une première infraction, d'une peine de prison d'une durée maximale de six mois, d'une amende maximale de 1 000 $ ou l'une de ces deux peines. Pour les infractions subséquentes, la loi prévoyait une peine d'emprisonnement maximale d'un an, une amende de 2 000 $ ou l'une de ces deux peines.

La *Loi sur les stupéfiants* et l'infraction de simple possession de cannabis

Lors des débats parlementaires concernant la Loi sur les aliments et drogues de 1969, le ministre de la Santé a proposé un amendement très important à la *Loi sur les stupéfiants*. De 1921 jusqu'à l'adoption de la *Loi sur les stupéfiants*, la législation canadienne avait contenu une infraction mixte dans le cas de simple possession d'une drogue. Or, depuis 1961, elle avait été uniquement considérée comme un acte criminel punissable d'une peine d'emprisonnement maximale de sept ans. La modification proposée en 1969 conservait cette infraction, mais offrait à nouveau la possibilité d'une poursuite par procédure sommaire, recréant ainsi une infraction mixte. Dans le cas d'une condamnation suite à une déclaration de culpabilité par procédure sommaire, s'il s'agissait d'une première infraction, la loi prévoyait une peine d'emprisonnement maximale de six mois, une amende maximale de 1 000 $ ou l'une de ces deux peines Pour les infractions subséquentes, une peine de prison d'une durée maximale d'un an, une amende de 2 000 $ ou l'une de ces deux peines. Cette modification avait été jugée nécessaire par le ministre de la Santé puisque le nombre de poursuites pour simple possession de cannabis était passé de 493 en 1966 à 1 727 en 1969.[81] Selon lui :

> *« [...] malgré l'énorme diversité des situations en cause, l'article pertinent de cette loi ne permet guère de flexibilité de la part des procureurs de la Couronne ni des juges ou des magistrats. Aucune disposition ne permet de juger sommairement. [...] Cette rigidité a provoqué de plus en plus de critiques dans bien des milieux, par exemple, les agences de recherches sur la toxicomanie de plusieurs provinces. »*[82]

Enfin, la Loi sur les aliments et drogues de 1969 apporta une modification à la procédure adoptée en 1929 prévoyant l'admissibilité du certificat d'un analyste fédéral au cours d'un procès pour une infraction concernant une drogue inscrite à l'annexe de la *Loi sur les stupéfiants* ou aux annexes G et J de la *Loi sur les aliments et drogues*. Désormais, il serait permis au procureur de la Couronne de prouver oralement sous serment, par affidavit ou déclaration solennelle, le statut du signataire du certificat qui n'avait plus à se présenter devant le tribunal. Toutefois, un juge pourrait exiger de l'analyste qu'il se présente devant lui afin d'être interrogé ou contre-interrogé pour

---

[80] Article 9 de la *Loi sur les aliments et drogues de 1969.*
[81] Hansard, Chambre des communes, 27 mars 1969, page 7203.
[82] Hansard, Chambre des communes, 27 mars 1969, page 7203.

mieux évaluer les renseignements inscrits dans l'affidavit ou la déclaration solennelle. Cette modification visait à garantir un plus grand respect des droits fondamentaux de l'accusé.

La Commission Le Dain (1969-1973)

Les parlementaires ont réclamé lors de l'étude des dispositions de la Loi sur les aliments et drogues de 1969 la création d'un comité spécial qui étudierait la problématique des drogues au Canada, plus particulièrement le cannabis, ce que le gouvernement libéral de Pierre-Elliott Trudeau fit le 29 mai 1969 par l'arrêté en conseil 1969-1112 qui créa la Commission d'enquête sur l'usage des drogues à des fins non médicales, mieux connue sous le nom de Commission Le Dain. L'un des motifs invoqués pour justifier sa création était :

> *« Que malgré lesdites mesures législatives et la surveillance exercée par la Gendarmerie royale du Canada et par d'autres forces policières pour assurer une stricte observation des prescriptions de la loi, le nombre des cas de possession et d'utilisation de ces substances à des fins non-médicales [sic] va en croissant, au point de nécessiter la tenue d'une enquête immédiate sur la cause de tels abus. »*[83]

L'organisation des travaux et les rapports de la Commission

Les travaux de la Commission se sont déroulés de la mi-octobre 1969 jusqu'au 14 décembre 1973, date du dépôt du rapport final. Au cours de cette période, elle a entendu 639 témoignages de groupes ou de particuliers ; 295 organismes ont présenté des mémoires et 43 ont témoigné devant les membres de la Commission ; 212 personnes ont présenté des mémoires et 89 ont témoigné oralement. Au total, elle a siégé dans 27 villes, incluant Ottawa et les dix capitales provinciales, et parcouru 50 000 milles à travers le pays. Au cours de son mandat, la Commission a publié quatre rapports : un rapport intérimaire (1970), un rapport spécial sur le cannabis (1972), un rapport sur le traitement (1972) et un rapport final (1973). Outre son président, Gérald Le Dain, elle était composée de quatre commissaires : Ian L. Campbell, Heinz Lehman, Peter Stein et Marie-Andrée Bertrand.

Avant de revoir les recommandations de la Commission sur le cannabis, il est utile de soulever quatre aspects des travaux de la Commission que madame Marie-Andrée Bertrand a soulevés devant de notre Comité.

Le premier concerne le mandat de la commission qui était « extrêmement généreux et ouvert » à savoir :

a) Utiliser les sources disponibles au Canada et à l'étranger, les données et l'information existant au sujet de l'usage à des fins non médicales des stupéfiants sédatifs, stimulants, tranquillisants, hallucinogènes et d'autres drogues et substances psychotropiques ;

---

[83] Le Dain, G., et coll., (1973) *Rapport final de la Commission sur l'usage des drogues à des fins non-médicales*. Ottawa : Gouvernement du Canada, page 4.

b) Rédiger un rapport sur la situation actuelle de la connaissance médicale par rapport aux effets de ces drogues [...];
c) Faire enquête et rédiger un rapport au sujet des motifs qui sous-tendent l'usage à des fins non médicales figurant en a) ;
d) Faire enquête et rédiger un rapport sur les facteurs sociaux, économiques, éducatifs et philosophiques relatifs à l'usage à des fins non médicales [...] en particulier, sur l'ampleur du phénomène, des facteurs sociaux qui le sous-tendent, les tranches d'âge des utilisateurs, et des problèmes de communication ; et
e) Faire enquête et établir des recommandations relatives à des orientations qui devraient être adoptées par le gouvernement fédéral, seules ou en collaboration avec d'autres paliers de gouvernement, pour réduire l'ampleur des problèmes d'un tel usage.

> *« L'amplitude de ce mandat a entraîné les commissaires et le personnel de la Commission dans un travail d'une grande envergure qui, à mon avis, a eu beaucoup d'impact sur la société canadienne. Malgré l'absence totale d'effet sur la législation pénale, la Commission Le Dain a provoqué un changement considérable des mentalités dans la population canadienne, suscitant une prise de conscience des effets des drogues traditionnelles… »*[84]

Deuxièmement, la méthode utilisée par la Commission pour aller chercher l'opinion des Canadiens. Après avoir mentionné les voyages de la commission, elle a rappelé que les audiences publiques donnaient au public l'opportunité de poser des questions et de confronter les experts.

> *« Nous avons donc suscité un grand débat national sur les facteurs qui font que la société canadienne …peut recourir à des substances psychotropes pour alléger certains de ses maux. À mon avis, la générosité du mandat, la méthode de consultation, le style et l'attitude des commissaires - et en particulier du président de la commission - ont engendré ce brassage d'idées sur la démocratie, sur le fonctionnement de l'État, et sur le sentiment d'aliénation que ressentaient et ressentent encore un grand nombre de Canadiens à l'endroit de leur gouvernement national, provincial ou municipal. »*[85]

Troisièmement, les recherches de la commission. Madame Bertrand a rappelé qu'au meilleur de son mandat, elle avait 100 personnes à son emploi, dont 30 chercheurs à temps plein. Ces chercheurs travaillaient essentiellement sur quatre cibles : (1) les effets des drogues, et notamment du cannabis, (2) l'usage des drogues, (3) les problèmes de traitement, et (4) l'influence des médias sur le phénomène.

Enfin, l'impact de la commission. Selon elle, le débat démocratique que la commission a suscité a eu des effets considérables au niveau des connaissances sur les

---

[84] Marie-Andrée Bertrand, professeure émérite de criminologie, Université de Montréal, Témoignage du comité spécial sur les drogues illicites, Sénat du Canada, Première Session de la trente-septième législature, 2001, page 45.
[85] *Ibid.*, page 46

drogues. Nombreux sont ceux qui ont compris que les stéréotypes du consommateur drogué et criminel étaient vraiment des stéréotypes. Concernant les prises de conscience sur les facteurs expliquant le désir de consommer, la commission a aussi provoqué une réflexion fondamentale. Enfin, rapidement après les débuts des travaux de la Commission, est apparu le sentiment d'aliénation de la population à l'endroit des politiques et des législateurs canadiens, ainsi que la frustration des citoyens de ne pas être entendus.

Le rapport spécial sur le cannabis

Avant de présenter leurs recommandations sur une nouvelle politique publique en matière de cannabis, les Commissaires ont fait plusieurs observations au sujet de la législation canadienne à l'égard de cette drogue.

- La décision de criminaliser le cannabis a été prise «*sans fondement scientifique évident ni même la conscience réelle d'un problème social* [...] ».[86]
- Le renversement du fardeau de la preuve qui s'opère au niveau de la procédure d'établissement de la preuve pour une infraction de possession en vue de trafic impose un fardeau très lourd à l'accusé – ce qui affaiblit grandement le principe de la présomption d'innocence – puisqu'il doit prouver par la supériorité des preuves (prépondérance des probabilités) qu'il n'avait pas l'intention de trafiquer et non pas uniquement en soulevant un doute raisonnable dans l'esprit du juge ou du jury.
- L'application de la loi est rendue très difficile par la nature même des infractions qui se produisent dans un milieu clandestin et souvent sur une base consensuelle, ce qui nécessite le recours à des méthodes exceptionnelles d'exécution de la loi. Or, *« l'effet de leur application dans le cadre des lois sur les stupéfiants est l'une des principales causes de l'inquiétude que suscitent les répercussions du droit criminel dans ce domaine. »*.[87]
- Les policiers de la GRC ainsi que ceux à l'emploi des services de police provinciaux ou municipaux ne disposent pas des ressources financières, humaines et techniques nécessaires pour faire, à la fois, échec au trafic de stupéfiants et s'occuper des délits de simple possession. Trop souvent, les cas de simple possession sont découverts par hasard au cours d'autres enquêtes policières ou de filatures s'échelonnant sur plusieurs mois, provoquant ainsi une application discriminatoire de la loi.
- Les choix de poursuites (mise en accusation ou procédure sommaire) varient considérablement d'une région à l'autre du pays, influencés par le nombre de causes impliquant des stupéfiants et la discrétion importante qu'exercent les procureurs de la Couronne en cette matière. Cette inégalité dans l'application de la loi peut avoir des conséquences extrêmement graves sur l'avenir d'un accusé notamment s'il hérite d'un casier judiciaire.[88]

---

[86] Le Dain, G., et coll., (1972) *Le cannabis : rapport de la Commission d'enquête sur l'usage des drogues à des fins non-médicales*. Ottawa : Gouvernement du Canada, page 231.

[87] *Ibid.*, page 241.

[88] *Ibid.*, page 247.

- L'imposition de sentences pour des infractions relatives aux drogues varie considérablement au Canada en raison des perceptions qu'ont les juges du problème de la toxicomanie, de leur expérience en droit pénal et des causes impliquant la simple possession ou le trafic de stupéfiants. Selon les recherches de la Commission, plus les juges étaient expérimentés dans ces deux domaines, moins sentences étaient sévères. Par exemple, dans le cas de simple possession, ils imposaient une amende ou la mise en liberté surveillée lorsqu'un accusé n'avait pas de casier judiciaire et, dans une affaire de trafic, une peine d'emprisonnement inférieure à deux ans.[89]
- De 1968 à 1971, la proportion des peines d'amendes imposées pour simple possession de cannabis est passé de 1 % de toutes les condamnations à plus de 77 %.[90]

Même si les commissaires s'entendaient sur ces observations, leurs conclusions et recommandations n'ont pas été unanimes.

L'opinion de la majorité : Les recommandations de Gérald Le Dain, Heinz Lehman et Peter Stein

Dans le but de mieux expliquer l'origine de ses recommandations, la majorité a fondé ses conclusions sur la notion de préjudice comme principal critère qui devait définir une nouvelle politique sociale en matière de cannabis. Ce principe est associé à la fois au préjudice que l'individu subit lorsqu'il utilise une substance nocive, plus particulièrement en ce qui a trait à sa santé physique ou mentale, et à celui qu'il fait subir à la société, c'est-à-dire les conséquences sur son milieu familial ou professionnel. La notion de préjudice était importante aux yeux de la majorité puisqu'elle permettait d'évaluer si la société devait se préoccuper des effets nuisibles du cannabis sur la santé humaine et la société et, si tel était le cas, dans quelles limites le droit pénal devait s'appliquer afin de les réduire. Devait-on criminaliser la simple possession de cannabis ou seulement son trafic ? Devait-on prévoir l'application de mesures telles la décriminalisation ou légalisation?

Dans un premier temps, la majorité a voulu éliminer certains mythes à l'égard des dangers du cannabis :

> *« La nocivité du cannabis est loin d'avoir été démontrée de façon complète et concluante. On trouve dans presque toute la preuve des défauts de méthodologie ou de raisonnement. […] Dans l'ensemble, les effets physiques et psychiques du cannabis aux niveaux actuels de la consommation en Amérique du Nord semblent beaucoup moins graves que ceux de l'alcoolisme. Toutefois, notre connaissance d'usages excessifs et persistants ne nous permet pas encore de tirer des conclusions fermes et définitives. »*[91]

---

[89] *Ibid.*, pages 249-250.
[90] *Ibid.*, page 251.
[91] *Ibid.*, pages 268-269.

En ce qui concerne le syndrome amotivationnel, elle a déclaré que la Commission n'avait pas de données concluantes sur la modification de la personnalité qu'entraînerait l'usage de cannabis.

> *« Certains observateurs évoquent l'apathie, la perte d'intérêt, la concentration sur le présent et le souci de l'avenir. Tous ces symptômes peuvent aussi bien témoigner d'une profonde transformation du système de valeurs et de l'attitude, transformation salutaire aux yeux de plusieurs. »*[92] *Selon la majorité, toutes « ces préoccupations justifient l'élaboration d'une politique restrictive visant à restreindre l'usage du cannabis, surtout chez les adolescents. »*[93]

La Commission ne disposait pas de données scientifiques précises et concluantes pour déterminer les effets nocifs ou bénéfiques du cannabis. Par contre, même si elle croyait que les dangers du cannabis étaient exagérés notamment en ce qui concerne la conduite d'un véhicule automobile, la polytoxicomanie, l'activité cérébrale à long terme et la criminalité, elle a tout de même reconnu que le cannabis, comme toutes les autres drogues, peut avoir des effets particulièrement nocifs lorsqu'il est consommé avec d'autres drogues et qu'il pouvait nuire au processus de développement des adolescents. La majorité a aussi expliqué que, même si l'usage du cannabis ne menaçait pas les fondements de la société canadienne ainsi que son système de valeurs basé, entre autres, sur une vie productive, on ne pouvait exclure cet élément comme facteur d'influence dans l'élaboration d'une nouvelle politique sur le cannabis.

Dans un deuxième temps, comme l'usage de cette substance comporte, en plus des problèmes de santé, des coûts familiaux et socio-économiques importants, la majorité a légitimé le recours au droit pénal en affirmant :

> *« À notre avis, il incombe à l'État de restreindre l'accessibilité des substances nocives [surtout pour les jeunes], et cette restriction relève à juste titre du droit pénal […] lorsqu'à son avis la possibilité d'un tort quelconque semble exiger de telles mesures. »*[94]

Pour cette raison, la majorité a rejeté le modèle de politique publique basée sur la légalisation de l'usage et de la distribution du cannabis. Même si la légalisation avait eu pour avantage de mieux contrôler l'offre et la qualité de cette drogue sans entraîner une augmentation considérable du nombre d'usagers à long terme, elle aurait pu entraîner le déplacement de certains consommateurs vers le haschich, dont la concentration de THC est plus forte ou inciter les usagers à consommer plus de cigarettes ou d'autres produits de cannabis afin d'obtenir l'effet psychoactif recherché. Ce qui aurait annulé

---

[92] *Ibid.*, page 272.
[93] *Ibid.*, page 276.
[94] *Ibid.*, page 283.

l'efficacité des mesures de contrôle et augmenté les risques d'abus. Cette politique aurait également rendu le produit plus accessible aux jeunes. [95]

Ainsi, la majorité préconisait le maintien des infractions de trafic, de possession en vue de trafic, d'importation et d'exportation de cannabis. Toutefois, dans le cas du contrôle de la demande, elle a adopté une position beaucoup plus libérale:

> *« Il ne faut pas avoir recours au droit pénal pour sanctionner la moralité sans égard à la nocivité réelle ou possible de l'acte lui-même. [...] Si nous admettons que la société a le droit d'avoir recours au droit pénal pour restreindre l'accessibilité à des substances nocives afin de protéger les individus [en particulier les jeunes] et la société, il ne s'ensuit pas nécessairement qu'il faudrait appliquer les dispositions du droit pénal à l'usager tout comme au distributeur. »* [96]

Dans ce contexte, des modifications à la Loi sur les stupéfiants s'imposaient puisque, selon la majorité : « *nous ne croyons pas qu'un changement à la loi fausserait nécessairement les jugements et la prudence qui, à notre avis, doit entourer le cannabis.* »[97] Ainsi, il fallait rétablir la confiance et le respect de la population canadienne envers la politique sur le cannabis en modifiant la classification des drogues inscrites à l'annexe de la loi, notamment celle du cannabis. La majorité s'appuyait sur le fait que :

> *« La Convention unique classe le cannabis avec les opiacés, mais elle n'exige pas des Parties qu'elles l'assujettissent aux mêmes dispositions pénales. Si on assimile à tort le cannabis aux opiacés, la Convention unique n'empêche certainement pas les législations nationales de corriger cette erreur. La classification et les dispositions législatives sont si généralement considérées comme erronées et indéfendables que toute modification propre à les rendre plus conformes aux faits susciterait probablement un plus grand respect et d'attention [envers la loi]. »* [98]

Le rétablissement de la confiance de la population dans la *Loi sur les stupéfiants* passait également par une révision complète des sanctions pénales relatives au cannabis. Pour ce faire, la majorité a insisté sur le fait que le préjudice qu'impose le droit pénal, plus particulièrement aux simples usagers, est plus grave que celui que pose la consommation de cette drogue sur leur santé ou leur environnement. Dans son analyse, la majorité s'est attardée aux conséquences des peines sur les jeunes puisque plus 85 % de tous ceux qui avaient été condamnés pour simple possession ou trafic de cannabis en 1970 et 1971 avaient moins de 25 ans.

Ainsi, l'imposition d'un casier judiciaire pouvait avoir des conséquences néfastes sur l'avenir des jeunes limitant les possibilités de déplacement et provoquait une certaine forme de stigmatisation familiale, sociale ou professionnelle à leur endroit. Selon la majorité, la possibilité d'obtenir un pardon, n'est pas suffisante pour amoindrir

---

[95] *Ibid.*, pages 285-288.
[96] *Ibid.*, page 283.
[97] *Ibid.*, page 292.
[98] *Ibid.*, page 292.

cette situation puisque : *« la condamnation est inévitablement connue d'un plus grand nombre et, le cas échéant, toute personne peut la découvrir par une investigation poussée. »*[99] En effet, la *Loi sur le casier judiciaire* prévoit seulement l'élimination des données du casier judiciaire entreposé dans les fichiers nationaux de la police suite à un pardon, mais non celles des rapports d'enquêtes policières ni des documents juridiques entreposés dans les Palais de justice relativement au procès et à la sentence et, encore moins des articles de journaux.

De plus, la majorité a condamné les peines excessives pour usage de cannabis en affirmant : « *Elles sont loin de correspondre aux préjudices que pourrait causer le cannabis. Elles sont d'ailleurs exagérées par comparaison avec celles qu'imposent la plupart des autres pays.* »[100] Elle a critiqué l'imposition d'une peine d'emprisonnement maximale de sept ans pour la culture de cannabis à des fins personnelles, l'existence d'une peine minimale de sept ans de prison pour l'importation ou l'exportation de drogues ainsi que la possibilité d'être emprisonné à vie pour trafic de cette drogue. La critique de la majorité portait aussi sur la définition de cette infraction. Comprenant le «don» ou «l'offre», des personnes pouvaient être accusées de trafic en raison du simple échange d'« un joint » lors d'une soirée entre amis. La majorité mentionnait aussi que la sévérité de ces peines était exacerbée parce que :

- Dans les poursuites relatives à la possession de cannabis en vue de trafic, la Couronne ne pouvait procéder que par voie de mise en accusation avec pour résultat l'imposition de peines plus élevées ; et
- L'application de la *Loi sur les stupéfiants* était discriminatoire (enquêtes policières, discrétion des procureurs de la Couronne dans le choix du mode de procès, le renversement du fardeau de la preuve au détriment de l'accusé et l'expérience des juges).

La criminalisation du cannabis avait un autre effet négatif puisque, comme la simple possession et la culture étaient illégales, cela encourageait la création d'un monde clandestin ou certains doivent commettre des crimes pour payer leur drogue ou, à tout le moins, fréquenter d'autres délinquants pour s'en procurer. Dans certains cas, la fréquentation d'un tel milieu pouvait inciter à l'utilisation de drogues dangereuses. Selon la majorité, pour un faible nombre d'usagers de cannabis :

> *« La légalisation du cannabis n'empêchera pas le recours au marché clandestin des autres drogues. Du point de vue de l'influence, les contacts entre usagers sont beaucoup plus redoutables qu'avec les trafiquants. La plupart des usagers sont amenés à d'autres drogues par des habitués, et il ne faudrait pas croire que la légalisation du cannabis ferait tomber l'intérêt pour les autres drogues. »*[101]

---

[99] *Ibid.*, page 293.
[100] *Ibid.*, page 294.
[101] *Ibid.*, page 297.

Enfin, l'utilisation de pouvoirs policiers extraordinaires tels les mandats de main-forte, souvent envers les usagers, ne faisaient que contribuer au discrédit de la loi et minait conséquemment le moral des forces policières.[102]

Pour toutes ces raisons, la majorité a recommandé que :

- L'importation et l'exportation soient comprises dans la définition de trafic, comme dans la *Loi sur les aliments et drogues*, et non passibles d'un période minimale d'emprisonnement ;
- La possibilité de procéder sommairement dans les affaires impliquant la possession de cannabis en vue de trafic et que la peine pour cette infraction soit ramenée, dans le cas d'une mise en accusation, à cinq ans et, lors d'une procédure sommaire, à 18 mois avec la possibilité d'une amende comme alternative à l'emprisonnement ;
- L'élimination de l'infraction de simple possession de cannabis ;
- Le retrait de la notion de «don» dans la définition de trafic si le cannabis est susceptible d'être consommé en une seule fois ;
- L'élimination de l'infraction de culture de cannabis pour des fins personnelles ; et
- L'allégement du fardeau de la preuve exigé de l'accusé dans le cas d'une poursuite pour possession à des fins de trafic en précisant dans la loi qu'il n'a qu'à susciter un doute raisonnable dans l'esprit du tribunal afin de ne pas être condamné pour trafic de stupéfiants.

Opinion minoritaire : Les recommandations de Marie-Andrée Bertrand

Pour Marie-Andrée Bertrand, la politique canadienne en matière de cannabis avait besoin d'une réforme sérieuse qui allait bien au delà de simples modifications à la *Loi sur les stupéfiants*. En ce sens, elle a adopté une approche beaucoup plus libérale que celle de la majorité et plus particulièrement, comme nous le verrons plus loin, de Ian L. Campbell. Selon elle, les recherches de la commission: *« [...] établissent qu'un grand nombre de personnes en ont consommé – un million ou davantage au Canada – et que très peu d'entre elles ont dû recourir aux soins d'un médecin ou d'un psychiatre pour en avoir fait usage. D'une manière générale, fumer de la marijuana ou du haschisch n'entraîne pas de graves problèmes personnels ni ne développe la criminalité. »*[103] De plus, les cas d'usage abusif du cannabis étaient exceptionnels puisque la majorité des usagers l'utilisait occasionnellement pour des fins récréatives. Ainsi, toute nouvelle politique publique visant à contrôler efficacement son usage sans toutefois causer de préjudice à la fois aux consommateurs et à la société devait tenir compte de ces éléments déterminants. Il fallait donc éliminer le recours au droit pénal. Selon la Commissaire, plusieurs arguments militaient en faveur d'une telle conclusion.

Tout comme la majorité, elle a d'abord rejeté plusieurs préjugés à l'égard de la nocivité du cannabis sur la santé humaine, notamment ses effets sur l'activité cérébrale

---

[102] *Ibid.*, pages 295-299.
[103] *Ibid.*, page 303.

et la conduite d'un véhicule automobile, reconnaissant néanmoins qu'à forte dose cette substance pouvait causer des psychoses. Même si Marie-Andrée Bertrand a reconnu que le cannabis pouvait nuire au développement d'un adolescent, elle a affirmé que bien peu de faits étayaient l'hypothèse avancée par la majorité.[104] Elle a également conclu que cette drogue ne provoquait pas la criminalité, l'agressivité ou le fameux syndrome amotivationnel.[105] Enfin, elle a rejeté l'argument voulant que le cannabis favorise la polytoxicomanie chez la plupart des usagers :

> *« Il est vrai qu'une certaine proportion d'usagers de cannabis prennent d'autres drogues. [...] Il ne s'agit pas d'un phénomène se limitant au cannabis, au L.S.D. et aux amphétamines, combinaison n'atteignant qu'une petite proportion d'usagers, – [sic] mais d'un recours presque aveugle à des produits agissant sur l'humeur de notre société. Compte tenu de la consommation d'alcool, on peut dire que les Canadiens font une grande consommation de psychotropes multiples, même si l'on exclut le cannabis. »*[106]

Deuxièmement, les usagers ne pouvaient pas s'assurer de la qualité du cannabis qu'ils achetaient avec toutes les conséquences que cela implique vu le caractère illégal et clandestin des moyens de production et de commercialisation. En ce sens, elle a répondu à l'argument de la majorité voulant que le contrôle de la qualité du cannabis dans un marché légal fasse en sorte que plusieurs consommateurs se déplaceraient vers le haschisch en précisant qu'aucune preuve d'une telle possibilité n'avait été établie.[107]

Troisièmement, la répression du commerce et de l'usage illicite de cannabis était coûteuse et inefficace. Le contrôle du trafic, malgré tous les efforts déployés par les agents de la GRC et les policiers municipaux ainsi que l'imposition de sanctions pénales sévères, était inefficace. Les peines prévues pour la simple possession n'avaient plus aucun effet dissuasif puisqu'un million de Canadiens faisaient ou avaient déjà fait usage de cannabis.

Quatrièmement, dans sa forme actuelle, la loi n'avait pas de caractère éducatif ou dissuasif puisque la perception qu'ont les Canadiens des préjudices que cause le cannabis n'était plus la même que celle du gouvernement. À ce sujet, Marie-Andrée Bertrand indiquait :

> *« Mais facteur plus important et sous-tendant les problèmes d'application de la loi, un changement progressif s'est opéré chez les Canadiens quant à la nocivité de cette substance. Il a fallu se rendre à l'évidence, le cannabis n'engendre pas de dépendance physique. On a contesté les opinions reçues. [...] Cependant, le maintien de l'interdiction du cannabis a provoqué chez de nombreux usagers un mépris général de la loi. »*[108]

---

[104] *Ibid.*, page 308.
[105] *Ibid.*, pages 307-309.
[106] *Ibid.*, page 308.
[107] *Ibid.*, page 309.
[108] *Ibid.*, page 304.

Pour toutes ces raisons, Marie-Andrée Bertrand recommandait la «légalisation contrôlée » du cannabis. En somme, le gouvernement fédéral devait retirer cette drogue de la *Loi sur les stupéfiants* et entreprendre des pourparlers avec les provinces en vue d'en soumettre la vente et la consommation à des contrôles semblables à ceux qui s'appliquent à l'alcool. Un tel système s'appuierait sur une réglementation permettant, d'une part, l'interdiction de la distribution ou la vente aux mineurs et, d'autre part, la mise en marché d'un produit de qualité et à un prix qui éliminerait tout risque de contrebande. Afin de garantir le succès d'une telle réforme, les gouvernements fédéral et provinciaux devaient collaborer afin de mettre au point des méthodes de production et de commercialisation tout en menant des recherches épidémiologiques multidisciplinaires afin d'évaluer les répercussions d'une politique de légalisation contrôlée sur la santé ou le comportement humain et déterminer les modalités d'usage.[109]

Enfin, pour Marie-Andrée Bertrand, cette politique serait bénéfique non seulement pour les usagers, mais également pour les gouvernements fédéral et provinciaux en raison des revenus considérables prévisibles provenant de la taxation des ventes d'un produit aussi populaire.[110]

Opinion minoritaire : Les recommandations d'Ian Campbell

Contrairement aux recommandations très libérales de Marie-Andrée Bertrand, celles proposées par Ian Campbell avaient un ton beaucoup plus conservateur. Bien qu'il se soit rallié aux conclusions de la majorité, il croyait fermement que la décriminalisation de la simple possession de cannabis serait mal interprétée par les médias et la population. Dans le cas de la légalisation, le signal envoyé à la société, plus particulièrement aux jeunes, serait que le cannabis est une drogue inoffensive et pourrait éventuellement mener à l'acceptation de l'usage d'autres drogues beaucoup plus dangereuses. À cet égard, il affirme que, dans les deux cas :

> *« Il y a risque aussi, à mon avis, que la levée de l'interdiction de la possession de cannabis, même par des adolescents, soit faussement interprétée comme une indication que la société est prête à accepter avec indulgence l'usage de la drogue, ce qui n'a pas été établi. Que les raisons d'une levée de l'interdiction soient mal interprétées ou non, je suis convaincu que cette libéralisation entrainerait une augmentation du nombre d'usagers. […] Le risque de cette progression est probablement moindre chez ceux pour qui la loi actuelle a eu un effet préventif que chez ceux qui ont déjà fait usage de cannabis, mais il est néanmoins réel pour un grand nombre. »* [111]

Selon lui, le maintien de la prohibition avait un avantage bénéfique, celui de protéger les jeunes contre les préjudices du cannabis :

---

[109] *Ibid.*, pages 310-311.
[110] *Ibid.*, page 304.
[111] *Ibid.*, page 312.

> *« Les dangers du cannabisme sont probablement moins graves chez les adultes que les jeunes, mais suffisamment de raisons, à mon avis, militent en faveur d'une interdiction absolue. L'une d'elle, et non la moindre, est l'impossibilité pratique où l'on se trouve actuellement d'avoir recours à la loi pour faire comprendre les dangers du cannabisme sans maintenir l'interdiction pour tous, jeunes ou vieux. »* [112]

Dans ce contexte, la loi servait les intérêts de la prévention et de la moralité en protégeant l'individu et la société. Poursuivant sur cette lancée, il a déclaré, à propos du cannabis et de l'immaturité des jeunes :

> *« On s'est inquiété récemment à juste titre des préjudices causés aux personnes qui doivent assumer prématurément trop d'obligations et de responsabilités. Il me semble, par contre, qu'on ne s'est pas assez préoccupé ces derniers temps des conséquences que peut avoir pour les jeunes un excès de libertés. »* [113]

Malgré tout, à l'instar des autres commissaires, il reconnaissait le fait que certaines sanctions pénales prévues par la loi puissent causer à certaines personnes un préjudice disproportionné par rapport à la nocivité réelle du cannabis sur la santé humaine et la société. Il a donc proposé le maintien des infractions de simple possession et de culture de cannabis, tout en précisant qu'elles ne devraient être jugées que par procédure sommaire et seraient passibles d'une amende de 25 $ pour la première infraction et de 100 $ à chaque récidive. Non seulement le maintien de la prohibition serait à l'avantage de l'usager, mais également des policiers puisqu'il :

> *« est tout à fait raisonnable de penser, en effet, que la plupart des personnes qu'on arrête pour possession de drogue, à la suite d'une enquête systématique de la police, sont effectivement coupables de trafic. »* [114]

Les travaux de la Commission Le Dain se sont terminés le 14 décembre 1973 avec le dépôt du rapport final. Le 31 juillet 1972, le ministre de la Santé, John Munro, avait dévoilé la politique que le gouvernement fédéral voulait suivre suite au dépôt du rapport spécial de la Commission sur le cannabis. Même s'il a refusé de légaliser l'usage du cannabis, le ministre a déclaré son intention de soustraire le cannabis à la *Loi sur les stupéfiants* afin de l'inscrire à la *Loi sur les aliments sur les drogues.* Cette mesure serait accompagnée d'un allégement des peines pour certaines infractions relatives à cette drogue, de programmes de recherche et d'éducation concernant son usage non médical et d'une atténuation des conséquences juridiques pour les usagers. Cette mesure aurait également englobé le haschisch puisque le gouvernement *« voulait faire une distinction claire entre cette drogue [cannabis] et les stupéfiants dangereux comme l'héroïne. »*[115] Deux ans plus tard, le 26 novembre 1974, le gouvernement fédéral déposait au Sénat le projet de loi S-19 afin de remplir ses engagements.

---

[112] *Ibid.*, page 313.
[113] *Ibid.*, page 314
[114] *Ibid.*, page 316
[115] Valois, D, « La marijuana et le haschisch ne seront pas légalisés », *Le Droit*, Ottawa, 1er août 1972.

Le projet de loi S-19 et le cannabis

Le projet de loi S-19 créait la Partie V de la *Loi sur les aliments et drogues* intitulée « Cannabis ». Ainsi, comme le recommandait l'opinion de la majorité dans le rapport spécial de la Commission Le Dain, cette drogue ainsi que ses usagers n'étaient plus soumis aux dispositions sévères de la *Loi sur les stupéfiants.*

L'article 7 du S-19 définissait « cannabis » comme étant le haschisch, la marijuana, le cannabidol ainsi que le THC. Il maintenait l'infraction de simple possession qui, toutefois, ne pouvait être poursuivie que par procédure sommaire. Quiconque en était déclaré coupable serait passible, dans le cas d'une première infraction, d'une amende maximale de 500 $ ou, à défaut de paiement, d'une peine d'emprisonnement maximale de six mois. Dans le cas d'une récidive, l'amende serait fixée à un montant ne pouvant dépasser 1 000 $ ou, à défaut de paiement, d'une peine de prison d'une période qui ne pouvait excéder six mois. Comme on peut le constater, le législateur privilégiait désormais l'amende à l'emprisonnement pour la simple possession.

Le projet de loi maintenait également les infractions de trafic, de possession en vue de trafic ainsi que de culture de cannabis sans permis prévues par la *Loi sur les stupéfiants*, passibles, sur déclaration de culpabilité par procédure sommaire, d'une amende maximale de 1 000 $, d'un emprisonnement maximal de 18 mois ou l'une de ces deux peines et, par une mise en accusation, d'une peine de prison d'une durée maximale de 10 ans. Les peines prévues étaient donc moins élevées que celles prévues par la Loi de 1961 sauf pour la culture de cannabis. En effet, même si le projet S-19 créait une infraction mixte pour ce crime, la peine d'emprisonnement maximale était beaucoup plus élevée (dix ans plutôt que sept lors d'une poursuite par voie de mise en accusation).

Enfin, lorsqu'une personne était reconnue coupable d'exportation ou d'importation de cannabis, elle s'exposait, dans le cas d'une déclaration de culpabilité par procédure sommaire, à une peine d'emprisonnement maximale de deux ans et, lors d'une mise en accusation, d'une peine minimale d'emprisonnement de trois ans pouvant aller jusqu'à quatorze ans. On voulait ainsi démontrer que les activités de trafic et de contrebande de cannabis étaient des crimes que le législateur jugeait encore et toujours comme très graves.

Outre ces infractions, le projet de loi S-19 comportait également les procédures criminelles incluses dans les parties III et IV de la *Loi sur les aliments et drogues* (preuve de possession en vue de trafic, certificat de l'analyste, pouvoirs policiers, etc.). Enfin, les dispositions concernant les règlements qui pouvaient être adoptés par le gouverneur en conseil concernant la délivrance de permis pour la culture et la simple possession de cannabis étaient désormais inscrites dans la nouvelle Partie V.

Le projet de loi a été étudié par le Comité sénatorial permanent des affaires juridiques et constitutionnelles. Le rapport de ce dernier recommandait trois amendements. Le premier ajoutait une disposition prévoyant une dérogation à *Loi sur le*

casier judiciaire à l'effet que toute personne qui fut absoute inconditionnellement ou sous condition bénéficierait automatiquement du pardon. Cette mesure avait pour but d'éliminer du Centre d'information de la police canadienne (CIPC) toute possibilité qu'un casier judiciaire subsiste après absolution. Le deuxième amendement portait de 10 à 14 ans moins un jour la peine d'emprisonnement maximale pour le trafic de stupéfiant. Le troisième abrogeait la peine minimale de trois ans pour contrebande.

Le projet de loi S-19 fut adopté le 15 juin 1975 en troisième lecture et a été envoyé à la Chambre des communes où il n'a jamais franchi l'étape de la deuxième lecture. À l'automne 1976, Mitchell Sharp a déclaré dans une entrevue que le projet ne serait pas réintroduit puisque des projets de lois plus importants étaient à l'étude.

APRÈS LE DAIN : LA FUITE EN AVANT

Tout au long des années 70, plusieurs politiciens fédéraux ont promis des réformes majeures afin d'alléger, voire d'éliminer, les sanctions pénales imposées aux usagers de cannabis. En 1972, le Parti libéral du Canada a inscrit dans sa plate-forme électorale son intention de modifier la politique canadienne sur la marijuana [116], ce qui a probablement donné naissance au projet de loi S-19. En 1978, le chef du Parti progressiste-conservateur, Joe Clark, a déclaré qu'un gouvernement formé par sa formation politique décriminaliserait la simple possession de cette drogue.[117] Toutefois, au début des années 80, les promesses de réforme ont cessé.

Au milieu des années 80, les Canadiens vont assister à une modification importante de la position du gouvernement fédéral à l'égard des drogues. Cette nouvelle réalité n'était peut-être pas étrangère à la politique américaine de «guerre contre la drogue » adoptée au début des années 80 par le Président Ronald Reagan. Désormais, les États-Unis redeviendront très actifs au sein des organisations internationales de contrôle des stupéfiants afin d'inciter la communauté internationale à prendre des mesures énergiques pour mettre fin au trafic de stupéfiants qui «menace la jeunesse américaine ».

En 1987, le Canada s'est activement impliqué dans les travaux de la Conférence internationale sur l'abus et le trafic de drogues illicites.[118] Deux événements importants se sont produits lors de cette réunion organisée sous l'égide des Nations Unies. Dans un premier temps, les délégués ont adopté un Schéma multidisciplinaire complet pour les activités futures de lutte contre l'abus des drogues encourageant les États à respecter leurs obligations en vertu des traités existants. Cette initiative ciblait quatre domaines importants : la prévention et la réduction de la demande de drogues illicites, le contrôle

[116] Spicer, L., *op. cit.*

[117] Giffen, P.J., et coll., *op. cit.*, page 571.

[118] Note d'information du Bureau de recherche du Parti progressiste-conservateur du Canada, 1er juin 1987

de l'offre, la suppression du trafic illicite, et le traitement et la réadaptation. Pour la première fois, les instruments juridiques internationaux prévoyaient explicitement la réduction de l'offre. Dans un deuxième temps, les délégués ont mis la dernière touche au traité visant à réprimer le trafic de stupéfiants à l'échelle mondiale. Ce traité fut adopté à Vienne le 20 décembre 1988 sous le nom de *Convention contre le trafic illicite de stupéfiants et de substances psychotropes* (Convention de 1988).

En plus de sa participation aux travaux ayant mené à l'adoption de cette convention, dès le milieu des années 1980, le Canada a multiplié ses activités sur la scène internationale en matière de drogues. En juin 1987, le Canada ratifie la Convention sur les substances psychotropes de 1971[119]; et promet d'accroître sa participation financière au Fonds des Nations Unies pour la lutte contre l'abus des drogues à 1 million $ d'ici 1991. Le gouvernement canadien justifiait sa participation sur la scène internationale en matière de stupéfiants en précisant que:

> [Traduction] *« Le gouvernement agit pour endiguer le flux de drogues qui entrent ou sortent du Canada, non seulement parce que les Canadiens sont victimes de toxicomanie, mais parce que nous avons aussi un rôle important à jouer comme citoyens responsables dans le monde. »*[120]

Cette lutte sur la scène internationale s'est transportée au pays lorsque le Parlement a adopté le 13 septembre 1988 avant même que le Canada n'ait signé ou ratifié la Convention de 1988 – ce qu'il fera en 1990 – le projet de loi C-61 qui visait à combattre le recyclage des produits de la criminalité (blanchiment d'argent, criminalité érigée en entreprise, etc.). Ce texte législatif visait le crime organisé et le financement de ses activités par le trafic des stupéfiants. Ainsi, le *Code criminel* et la *Loi sur les stupéfiants* étaient amendés afin de créer deux nouvelles infractions : le recyclage des produits de la criminalité et la possession de biens obtenus grâce au trafic de stupéfiants. Ces deux nouvelles dispositions s'appliquaient également aux activités illégales de culture, de trafic, d'exportation et d'importation de drogues au Canada ou à l'étranger si elles étaient commises par des citoyens canadiens. Le Parlement n'avait pas besoin de légiférer pour criminaliser les autres activités interdites par la Convention de 1988 puisque, comme nous l'avons vu, la plupart d'entre elles l'étaient déjà depuis 1961.

La Loi réglementant certaines drogues et autres substances

Conformément à l'engagement pris en 1987 par le gouvernement fédéral, le ministre de la Santé, Perrin Beatty, a déposé le projet de loi C-85, la *Loi sur les substances psychotropes*, le 11 juin 1992. Ce texte législatif fusionnait les Parties III et IV de la *Loi sur*

---

[119] International Narcotics Control Board, (1988) *Report of the International Narcotics Control Board for 1987*, Vienne : Organisation des Nations Unies, page 21.

[120] Note d'information du Bureau de recherche du Parti progressiste-conservateur du Canada, 1er juin 1987

les aliments et drogues ainsi que la *Loi sur les stupéfiants* en une seule loi. Le projet de loi C-85 n'a jamais franchi l'étape du rapport à la Chambre des communes et est mort au Feuilleton, en septembre 1993, lors de la dissolution de la 34e Législature pour la tenue d'élections fédérales.

Le 2 février 1994, la nouvelle ministre de la Santé, Diane Marleau, a ressuscité la mesure législative proposée par l'ancien gouvernement sous un nom différent : la *Loi réglementant certaines drogues et autres substances* (LRDS). Il a été adopté par la Chambre des communes le 30 octobre 1995. Après la prorogation de la première session de la 35e Législature, il fut réintroduit au Sénat le 6 mars 1996 et renuméroté C-8. Il est entré en vigueur le 20 juin 1996.

Il s'agissait de la première réforme majeure de la législation canadienne antidrogue depuis la fin des années 60. Excepté les modifications apportées en 1988 avec le projet C-61, la *Loi sur les stupéfiants* avait été modifiée en 1985 afin d'abolir le recours au mandat de main-forte et la procédure permettant d'établir la preuve pour possession de stupéfiants en vue de trafic. En 1987, la Cour suprême du Canada dans l'arrêt *R. c. Smith*, avait en effet déclaré inconstitutionnelle la peine d'emprisonnement minimale de sept ans pour une infraction d'exportation ou d'importation en vertu de l'article 12 de la *Charte canadienne des droits et libertés* (peine cruelle ou inusitée), entraînant ainsi son abrogation.

Un des objectifs du projet de loi C-8 était de satisfaire aux obligations internationales du Canada dans le cadre de la *Convention unique sur les stupéfiants* (1961), de la *Convention sur les substances psychotropes* (1971), ainsi que de la *Convention des Nations Unies contre le trafic illicite des stupéfiants et des substances psychotropes (Convention de Vienne, 1988).* » De plus, il visait à instaurer un cadre législatif permettant de réglementer l'importation, la production, l'exportation, la distribution et l'utilisation des substances se trouvant aux annexes des lois antérieures. Les sections suivantes décrivent les principales dispositions de cette nouvelle mesure législative.

<u>Les substances</u>

La fusion de l'annexe de la *Loi sur les stupéfiants* avec les annexes des *Lois sur les aliments et drogues de 1961 et 1969*, combiné à l'ajout de nouvelles substances telles les benzodiazépines ainsi que les précurseurs de cette longue liste de substances, a considérablement augmenté le nombre de drogues soumises aux dispositions et procédures contraignantes de la LRDS.

L'expression «substance désignée» s'entend aux substances inscrites à l'une ou l'autre des annexes I, II, III, IV et V. De plus, la loi définit le terme « analogue » comme toute substance dont la structure chimique est essentiellement la même que celle d'une substance désignée. Aussi, toute chose contenant une substance désignée et servant, ou destinée à servir ou conçue pour servir, à la produire ou à l'introduire dans le corps humain sera traité comme cette substance illicite.

- **Annexe I :** des stupéfiants comme l'opium, la morphine et la cocaïne.

- **Annexe II :** le cannabis, le haschisch, cannabinol, etc.
- **Annexe III** : des stimulants comme les amphétamines, des hallucinogènes comme la mescaline, le LSD et le DET, et des sédatifs comme le méthaqualone, communément appelé quaalude.
- **Annexe IV** : entre autres les stéroïdes anabolisants, et les hypnotiques comme les barbituriques et les benzodiazépines (mieux connus sous leurs marques de commerce Seconal, Luminal, Valium et Librium).
- **Annexe V** : énumère autres substances pouvant donner lieu à abus.
- **Annexe VI** : les précurseurs – ils ne produisent pas d'effet sur le psychisme, mais ils peuvent être convertis ou utilisés pour produire des drogues "designer", des "simili-drogues" ou des substances figurant dans les annexes suivant les obligations internationales que le Canada a contractées en vertu de la *Convention unique sur les stupéfiants* (1961) et de la *Convention de Vienne* de 1988.
- **Les annexes VII et VIII :** concernent l'application des peines pour les infractions liées au cannabis.

Au total, plus de 150 drogues, substances psychotropes et précurseurs se trouvent maintenant dans les annexes de la loi. Il est à noter que l'article 60 de la LRDS maintient la disposition adoptée en 1911 prévoyant que le gouverneur en conseil peut, par décret, modifier l'une ou l'autre des annexes de la loi en y ajoutant ou supprimant une ou plusieurs substances si cela lui paraît nécessaire dans l'intérêt public.

Partie I : Les infractions et les peines

La participation aux activités susmentionnées n'entraînerait pas nécessairement de sanctions criminelles. Comme on le verra plus loin, la loi prévoit des règlements autorisant la possession, l'importation ou l'exportation et la production à des fins médicales, scientifiques, industrielles ou d'application de la loi. La Partie I de la LRDS énumère plusieurs types d'infractions :

(1) La possession d'une substance inscrite à l'annexe I, II ou III (paragraphe 4(1)); l'obtention, ou chercher à obtenir, une substance inscrite à l'annexe I, II, III ou IV, ou l'ordonnance nécessaire à son obtention auprès d'un praticien (paragraphe 4(2). Le tableau qui suit indique les peines maximales pour l'infraction de possession[121]:

Possession d'une substance inscrite à l'annexe I

[121] Les tableaux des peines dans cette section sont reproduits du texte *Projet de loi C-8 :Loi réglementant certaines drogues et autres substances*, Résumé législatif 240, préparé par Jane Allain, Division du droit et du gouvernement, Direction de la recherche parlementaire, Bibliothèque du Parlement, 20 mars 1996 (révisé le 1er mai 1997).

Acte criminel Procédure sommaire Récidive :	Emprisonnement de sept ans Amende de 1 000 $ ou 6 mois de prison, ou les deux Amende de 2 000 $ ou emprisonnement d'un an, ou les deux
Possession d'une substance de l'annexe II (cannabis sous toutes ses formes) :	
Acte criminel Procédure sommaire Récidive	Emprisonnement de 5 ans moins un jour Amende de 1 000 $ ou 6 mois de prison ou les deux Amende de 2 000 $ ou un an de prison ou les deux
Possession d'une substance de l'annexe VIII (moins de 1 g de résine de cannabis (haschich) ou moins de 30 g de marijuana)	
Procédure sommaire seulement	Amende de 1 000 $ ou 6 mois de prison ou les deux
Possession d'une substance inscrite à l'annexe III	
Acte criminel Procédure sommaire Récidive	Emprisonnement de 3 ans Amende de 1 000 $ ou 6 mois de prison ou les deux Amende de 2 000 $ ou un an de prison ou les deux

Les pénalités imposées pour l'infraction au paragraphe 4(2) sont semblables mais varient légèrement des peines prévues pour l'infraction de possession.

(2) De faire le trafic de toute substance inscrite aux annexes I, II, III ou IV ou de toute substance présentée ou tenue pour telle. Le trafic est défini comme toute opération de vente, d'administration, de don, de cession, de transport, d'expédition ou de livraison relativement à la substance inscrite, ou toute offre d'effectuer l'une de ces opérations. La «vente » comprend le fait de mettre en vente, d'exposer ou d'avoir en sa possession pour la vente ou de distribuer, que la distribution soit faite ou non à titre onéreux (paragraphe 5(1)) ; de posséder toute substance inscrite aux annexes I, II, III ou IV en vue d'en faire le trafic (paragraphe 5(2)). Le tableau qui suit indique les peines <u>maximales</u> pour ces infractions :

Trafic d'une substance inscrite à l'annexe I ou à l'Annexe II (sauf dans les cas de moins de 3 kg de cannabis)	
Acte criminel : Pas de procédure sommaire	Emprisonnement à vie
Trafic d'une substance inscrite à l'Annexe III	
Acte criminel Procédure sommaire	Emprisonnement de 10 ans Emprisonnement de 18 mois
Trafic d'une substance inscrite à l'Annexe IV	
Acte criminel Procédure sommaire	Amende de 1 000 $ ou 6 mois de prison ou les deux Emprisonnement d'un an

Le trafic de cannabis ne donnerait pas toujours lieu à une peine maximale d'emprisonnement à vie. Dans les cas de trafic de moins de 3kg de cannabis, la personne est coupable d'un acte criminel et sujet à une peine maximale de 5 ans moins un jour.

(3) De faire importation ou exportation de toute substance inscrite à l'une ou l'autre des annexes I à VI (paragraphe 6(1)); d'avoir en sa possession toute substance inscrite à l'une ou l'autre des annexes I à VI en vue de son exportation (paragraphe 6(2)). Le tableau qui suit indique les peines maximales pour ces infractions :

Importation ou exportation d'une substance inscrite à l'Annexe I ou II	
Acte criminel : Pas de procédure sommaire	Emprisonnement à vie
Importation ou exportation d'une substance inscrite à l'Annexe III ou VI	
Acte criminel Procédure sommaire	Emprisonnement de 10 ans Emprisonnement de 18 mois
Importation ou exportation d'une substance inscrite à l'Annexe IV	
Acte criminel Procédure sommaire	Emprisonnement de 3 ans Emprisonnement d'un an

(4) La production de toute substance inscrite aux annexes I, II, III ou IV. La production est définie comme le fait de l'obtenir par quelque méthode que ce soit, et notamment par la fabrication, la synthèse ou tout autre moyen altérant ses propriétés physiques ou chimiques, ou la culture, la multiplication ou la récolte de la substance ou d'un organisme vivant dont il peut être extrait ou provenir de toute autre façon. Le tableau qui suit indique les peines maximales pour cette infraction :

Production d'une substance inscrite à l'annexe I ou II (autre que le cannabis ou la marijuana)	
Acte criminel Pas de procédure sommaire	Emprisonnement à vie
Production de cannabis (marijuana) (moins de 1 g de résine de cannabis (haschich) ou moins de 30 g de marijuana)	
Acte criminel Pas de procédure sommaire	Emprisonnement de 7 ans

Production d'une substance inscrite à l'Annexe III	
Acte criminel Procédure sommaire	Emprisonnement de 10 ans Emprisonnement de 18 mois
Production d'une substance inscrite à l'annexe IV	
Acte criminel Procédure sommaire	Emprisonnement de 3 ans Emprisonnement d'un an

(5) La possession de biens d'origine criminelle (article 8); et les infractions liées au recyclage du produit d'activités criminelles (article 9).

Il est évident que les peines pour les infractions sont liées de près à l'annexe où figure la substance en cause. De plus, les peines fixées pour les infractions relatives au cannabis varient également beaucoup selon la quantité confisquée, sujet qui sera discuté plus en détail ci-dessous.

L'article 10 de la loi énonce l'objectif des peines prononcées : de contribuer au respect de la loi et au maintien d'une société juste, paisible et sûre tout en favorisant la réinsertion sociale des délinquants et, dans les cas indiqués, leur traitement et en reconnaissant les torts causés aux victimes ou à la collectivité. De plus, cet article énumère une liste de facteurs que le tribunal doit considérer comme circonstances "aggravantes" en déterminant la peine à imposer à une personne reconnue coupable d'une infraction désignée. Les facteurs à considérer sont les suivants : l'utilisation d'une arme ou le recours ou la menace de recourir à la violence, le trafic d'une substance sur le terrain d'une école ou dans un lieu public fréquenté par des mineurs, ou auprès d'une personne de moins de 18 ans, et toutes condamnations antérieures pour une infraction liée à la drogue. De plus, l'utilisation des services d'un mineur pour perpétrer une infraction désignée constitue des circonstances aggravantes. Le juge qui déciderait de n'imposer aucune peine d'emprisonnement en présence d'une ou de plusieurs des circonstances aggravantes est tenu de justifier sa décision.

Partie II : Exécution et mesures de contrainte

Les articles 11 et 12 de la loi traitent des activités de perquisitions, de fouilles et de saisies. Ces thèmes sont discutés plus en profondeur dans le chapitre 14.

L'article 13 incorpore certaines dispositions du *Code criminel* établissant un plan détaillé pour la restitution, le renvoi ou la détention des biens saisis. Dans le cas de biens infractionnels, les articles *Code criminel* s'appliquent sous réserve des articles 16 à 22 de la loi. De plus, une procédure distincte est établie dans les articles 24 à 29 pour déterminer la disposition des substances désignées. Il est à noter que l'article 14 permet d'émettre une ordonnance de blocage contre un bien infractionnel

Les articles 16 et 17 traitent de la confiscation de biens infractionnels. Un bien infractionnel est défini comme tout bien situé au Canada ou non – à l'exception des

substances désignées ou des biens immeubles, sauf si ces derniers ont été construits ou ont subi d'importantes modifications en vue de faciliter la perpétration d'une infraction désignée – qui sert ou donne lieu à la perpétration d'une infraction désignée ou qui est utilisé de quelque manière dans la perpétration d'une telle infraction, ou encore qui est destiné à servir à une telle fin. Le tribunal qui déclare une personne coupable d'une infraction désignée doit ordonner la confiscation des biens infractionnels s'il est convaincu, selon la prépondérance des probabilités, que les biens sont liés à la perpétration de l'infraction. Lorsque les biens infractionnels ne peuvent être liés à l'infraction dont la personne est accusée, le tribunal pourrait quand même en ordonner la confiscation. Le tribunal peut rendre cette ordonnance à la condition d'être convaincu, hors de tout doute raisonnable, qu'il s'agit de biens infractionnels. De plus, des biens infractionnels peuvent être confisqués même si des procédures judiciaires n'ont jamais été engagées. Le juge doit rendre une ordonnance de confiscation s'il est convaincu que les conditions suivantes sont réunies : les biens sont, hors de tout doute raisonnable, des biens infractionnels; des procédures ont été engagées relativement à une infraction désignée ayant trait à ces biens; la personne accusée de l'infraction est décédée ou s'est esquivée.

Les articles 18 à 22 reprennent essentiellement les mêmes éléments que ceux qui figurent dans les articles 462.4 à 462.45 du *Code criminel*. Le but de ces articles est de protéger les intérêts des tiers innocents et des acheteurs de bonne foi. Règle générale, si le tribunal est convaincu de la véracité de la réclamation, il peut ordonner que le bien soit restitué (ou le paiement de sa valeur si ce n'est pas possible de le restituer) à la personne qui en est le propriétaire légitime ou qui a droit à sa possession.

L'article 23 ne fait qu'incorporer les dispositions du *Code criminel* ayant trait à la confiscation du produit de la criminalité. En conséquence, les mêmes modalités sont établies dans le cas de la confiscation du produit d'infractions désignées.

Partie III – Disposition des substances désignées

En vertu du paragraphe 13(4) de la loi, lorsqu'une substance désignée a été saisie un rapport décrivant le lieu perquisitionné, la substance saisie et l'endroit où elle est gardée doit être déposé au juge de paix de la circonscription concernée. Les articles 24 à 29 de la loi régissent la disposition des substances désignées.

L'article 24 établit la procédure avant le procès pour la restitution de substances désignées. Par exemple, toute personne peut, dans les 60 jours suivant la date où une substance désignée a été saisie, trouvée ou obtenue par un agent de la paix ou un inspecteur, demander à un juge de paix de lui en ordonner la restitution. Si le juge est convaincu du bien-fondé de la demande, il ordonne que la substance soit restituée au demandeur. Dans le cas contraire, le juge ordonne la confiscation au profit de la Couronne. La substance est alors disposée conformément aux règlements applicables ou, à défaut, selon les instructions du ministre. À défaut de demande de restitution la substance est remise au ministre et est disposée conformément aux règlements applicables ou, à défaut, selon les instructions du ministre.

Il est à noter que l'article 26 permet au ministre de demander au juge de paix d'ordonner qu'une substance désignée soit confisquée, à tout moment, s'il a des motifs de croire que celle-ci risque de porter atteinte à la sécurité ou à la santé publique. La demande se fait essentiellement par procédure *ex parte*. Si le juge de paix décide que le ministre a des motifs raisonnables de croire que la substance risque de porter atteinte à la sécurité ou à la santé, il en ordonne la confiscation. La substance est disposée conformément aux règlements applicables ou, à défaut, selon les instructions du ministre.

L'article 27 réglemente la procédure après le procès pour la restitution des substances désignées saisies - la personne qui s'est fait saisir la substance a droit à sa restitution si le tribunal juge ses activités légitimes. Autrement, la substance est restituée au véritable propriétaire légitime, pourvu que cette personne puisse être identifiée. Dans ni l'un ni l'autre des cas, la substance est confisquée au profit de la Couronne qui en dispose conformément aux règlements applicables ou, à défaut, selon les instructions du ministre.

L'article 28 permet au ministre à disposer d'une substance désignée avec l'assentiment du propriétaire.

Finalement, l'article 29 permet au ministre de faire détruire les plantes dont peuvent être extraites les substances inscrites aux annexes I, II, III ou IV et qui sont produites sans permis réglementaire ou en violation de celui-ci.

Partie IV : Contrôle d'application

Cette partie porte sur les pouvoirs attribués aux inspecteurs pour veiller à ce que le titulaire d'une autorisation ou d'une licence réglementaire l'habilitant à se livrer à des opérations à l'égard de substances désignées or des précurseurs soit respectueux des règlements.

L'inspecteur peut procéder, à toute heure convenable, à la visite de tout lieu où il a des motifs raisonnables de croire que le titulaire exerce son activité commerciale ou professionnelle. La loi autorise les inspecteurs à commettre une série d'actes reliés à l'inspection, y compris saisir et retenir toute substance désignée ou tout précurseur dont il juge, pour des motifs raisonnables, la saisie et la rétention nécessaire. La loi prévoit des dispositions traitant de la restitution des biens saisis. Il est à noter que dans le cas de local d'habitation, il faut d'abord que l'inspecteur obtienne le consentement de l'occupant ou qu'il soit muni d'un mandat.

Partie V : Ordonnances administratives pour violation de règlements spéciaux

Cette partie a pour effet de prévoir la procédure administrative à suivre lorsqu'il y a contravention des règlements désignés "spéciaux" par le gouverneur en conseil. L'article 33 de la LRDS permet au gouverneur en conseil de proclamer certains textes réglementaires adoptés en vertu de l'article 55 comme étant des *« règlements spéciaux »*. Le non-respect de ces derniers peut entraîner des ordonnances administratives comportant

des sanctions sévères, y compris la révocation du permis ou de licence qui avait été délivré par le ministère de la Santé (paragraphes 40(4)).

Partie VI : Dispositions générales

Les articles 44 à 60 prévoit des dispositions générales. Par exemple, les articles 44, 45 et 51 traite de la désignation des analystes, l'envergure de leurs fonctions et l'admissibilité de leurs rapports dans un procès.

L'article 46 crée une peine générale qui s'applique à quiconque contrevient à une disposition de la présente loi pour laquelle aucune peine n'est spécifiquement prévue ou à un règlement. Un acte criminel est puni d'une amende maximale de 5 000 $ et/ou d'un emprisonnement de trois ans. Une infraction menant à une déclaration de culpabilité par procédure sommaire donne lieu à une amende de 1 000 $ et/ou à six mois de prison.

En vertu de l'article 47, la période pour entreprendre les poursuites par procédure sommaire pour certaines infractions à la loi et aux règlements est d'un an. Toutes les autres questions de procédure sommaire se prescrivent par six mois à compter de la perpétration.

D'autres articles traitent des questions suivantes : que le poursuivant n'a pas, sauf pour réfutation, à établir qu'un certificat, une licence, un permis ou tout autre titre ne joue pas en faveur de l'accusé(article 48) ; qu'une copie d'un document déposé auprès d'un ministère est admissible en preuve sans qu'il soit nécessaire de prouver l'authenticité de la signature de l'autorité (article 49) ; qu'un certificat délivré à un agent de police exemptant ce dernier de l'application de la loi ou de son règlement est admissible en preuve dans le cadre d'une procédure et, sauf preuve contraire, fait foi de la validité de sa délivrance et de son contenu sans qu'il soit nécessaire de prouver l'authenticité de la signature qui y est apposée ou la qualité officielle du signataire - la défense peut, avec l'autorisation du tribunal, contre-interroger la personne qui a délivré le certificat (article 50); que la signification de tout document peut être prouvée par témoignage, affidavit ou déclaration solennelle, bien que le tribunal puisse quand même exiger que le signataire comparaisse (article 52); que la continuité de la possession d'une pièce présentée comme preuve dans le cadre d'une procédure peut être établie par le témoignage de la personne qui prétend l'avoir eue en sa possession, ou par l'affidavit ou la déclaration solennelle de celle-ci (article 53) ; et que des copies certifiées de livres, registres, données électroniques ou autres documents saisis peuvent être présentes comme preuve admissible par le procureur - la version copiée aurait la même force probante que l'original, à moins que l'accusé présente des preuves à l'effet contraire (article 54).

Le paragraphe 55(1) établit le pouvoir du gouverneur en conseil de prendre des règlements. L'un des objectifs de la politique canadienne antidrogue était le contrôle du commerce légal des drogues inscrites à l'annexe à des fins médicales ou scientifiques. La LRDS augmentait de façon importante le pouvoir du gouverneur en conseil de prendre des règlements relativement aux substances désignées et aux précurseurs. Les règlements pris en vertu de la LRDS s'appliquent notamment aux entreprises, aux

médecins et aux pharmaciens. Ainsi, le gouverneur en conseil peut adopter les règlements qui suivent concernant les substances désignées ou les précurseurs :

- Régir, autoriser contrôler ou restreindre l'importation et l'exportation, la production, l'emballage, l'expédition, le transport, la livraison, la vente, l'administration, la possession ou l'obtention.
- Délivrer les permis aux entreprises ou personnes permettant les activités susmentionnées, définir les modalités de paiements et leur révocation, et déterminer les qualifications requises des titulaires de permis.
- Contrôler les méthodes de production, d'entreposage, d'emballage et restreindre la publicité, si nécessaire, pour la vente de ces substances;
- Régir les livres, registres, données électroniques ou autres documents que doivent établir les entreprises, les médecins, les pharmaciens ou toute autre personne titulaire d'un permis qui se livrent aux activités mentionnées au premier point.
- Autoriser, si nécessaire, la communication de renseignements obtenus en vertu des enquêtes menées par les inspecteurs du ministère de la Santé aux autorités provinciales lors d'une contravention grave aux règlements concernant les activités définies au premier point afin qu'elles puissent prendre des mesures disciplinaires.
- Soustraire, aux conditions précisées dans les règlements, toute personne ou catégorie de personne à l'application de l'article 55.

Le paragraphe 55(2) permet au gouverneur en conseil, sur la recommandation du Solliciteur général du Canada, de prendre des règlements ayant trait aux investigations et à d'autres activités d'application de la loi. Cela comprend des règlements soustrayant les agents de police, dans certaines circonstances, de l'application de la partie I de la loi (les infractions et les peines).

En vertu de l'article 56, le ministre peut soustraire, aux conditions qu'il ou elle fixe, à l'application de tout ou partie de la présente loi ou de ses règlements toute personne ou catégorie de personnes, ou toute substance désignée ou tout précurseur ou toute catégorie de ceux-ci, s'il ou elle estime que des raisons médicales, scientifiques ou d'intérêt public le justifient. L'article 57 traite de la délégation des pouvoirs du ministre et du Solliciteur général.

L'article 58 précise que les dispositions de la loi ou de ses règlements l'emportent respectivement sur les dispositions incompatibles de la *Loi sur les aliments et drogues* ou de ses règlements.

L'article 59 crée une infraction de faire ou consentir à ce que soit faite une déclaration fausse ou trompeuse, participer à une telle déclaration ou y acquiescer, dans un livre, registre, rapport ou autre document à établir aux termes de la loi ou de ses règlements,.

Tel que mentionné, le gouverneur en conseil est habilité, en vertu de l'article 60, à modifier l'une ou l'autre des annexes pour y ajouter ou en supprimer une substance nommée.

Le cas particulier du cannabis

La première version de la LRDS maintenait le cannabis à l'annexe où l'on trouvait les drogues les plus dangereuses et auxquelles les sanctions criminelles les plus sévères décrites plus haut s'appliquaient. Afin de faire taire les critiques, le gouvernement a accepté de retirer le cannabis de l'annexe I et a créé les annexes II, VII et VIII qui portent exclusivement sur cette drogue. Ainsi, l'annexe II définit le cannabis comme étant la marijuana, la résine de cannabis (haschisch), le cannabinol, etc. L'annexe VII établissait à 3 kilogrammes de cannabis ou haschisch la quantité maximale qui permettait l'imposition d'une peine moins sévère pour trafic ou possession en vue de trafic de cette substance. Enfin, l'annexe VIII précisait qu'une personne qui avait en sa possession pour des fins personnelles moins d'un gramme de haschisch ou moins de 30 grammes de cannabis était passible de sanctions criminelles moins sévères que celle prévues pour l'annexe II.

Ainsi, si une personne est reconnue coupable de simple possession, de possession en vue de trafic ou de trafic d'une quantité supérieure à celle définie aux annexes VII et VIII, les peines plus sévères prévues par la Partie I pour les drogues inscrites aux annexes I ou II s'appliquent. Dans le cas contraire, la LRDS définit des nouvelles sanctions pénales. Ainsi pour ce qui est de l'annexe VIII, l'article 4 de la LRDS prévoit qu'une personne accusée de simple possession de cannabis ne peut être poursuivie que par procédure sommaire et prévoit une peine d'emprisonnement maximale de six mois, une amende maximale de 1 000 $ ou l'une de ces deux peines. Contrairement à ce qu'avait recommandé l'opinion majoritaire dans le rapport spécial de 1972 de la Commission Le Dain relativement à la réduction de la peine imposée aux infractions d'importation et d'exportation de cannabis, l'emprisonnement à perpétuité continue de s'y appliquer. Enfin, la peine d'emprisonnement maximale de sept ans prévue par la *Loi sur les stupéfiants* pour l'infraction de culture (production) de cette drogue demeure inchangée avec la LRDS.

CONCLUSIONS

Conclusions du chapitre 12
➢ **Les premières législations sur les drogues étaient largement fondées sur une panique morale, des sentiments racistes et une absence notoire de débats.**
➢ **Les législations sur les drogues ont souvent prévu des dispositions particulièrement sévères, telles le renversement du fardeau de la preuve et des sentences cruelles et inusitées.**
➢ **Les travaux de la Commission Le Dain ont jeté les bases d'une approche plus rationnelle de la politique**

	sur les drogues illicites en tentant de s'appuyer sur des données issues de la recherche. ➢ **Les travaux de la Commission Le Dain n'ont eu aucune suite législative, sauf en 1996 dans certaines dispositions de la Loi réglementant certaines drogues et autres substances, notamment en matière de cannabis.** ➢ **Les propositions de réforme lancées au cours des années 1970, notamment pour la décriminalisation du cannabis, n'ont eu aucune suite.** ➢ **Trente ans après la Commission Le Dain, les dispositions législatives et leur application n'ont eu aucun effet notable sur l'offre et la demande de cannabis.** ➢ **La Loi actuelle ne tient pas compte des données issues de la recherche sur les effets comparés de diverses substances, notamment sur les effets du cannabis.**

CHAPITRE 13

RÉGLEMENTER L'UTILISATION DU CANNABIS À DES FINS THÉRAPEUTIQUES

Nous avons vu au chapitre 9 que le cannabis a été utilisé à des fins thérapeutiques dans diverses sociétés depuis plusieurs milliers d'années, souvent pour les mêmes conditions physiques que celles pour lesquelles des personnes en font usage aujourd'hui. Mais à compter du début du XXe siècle, la communauté médicale a graduellement cessé de prescrire du cannabis. Divers facteurs peuvent expliquer cette évolution. Les développements de l'industrie pharmaceutique au cours du XIXe siècle ont fourni à la communauté médicale d'autres médicaments, plus stables et éprouvés cliniquement. L'approche de la médecine elle-même a changé et conséquemment la conception même de la santé. Et les drogues issues de plantes source, d'abord l'opium puis la coca et le cannabis ont fait l'objet d'un interdit par la communauté internationale, sauf à des fins médicales et scientifiques. Or, dans le cas du cannabis, il n'y avait pas eu, jusqu'à tout récemment, d'études permettant d'établir ses propriétés médicales selon les règles méthodologiques admises.

Néanmoins, on a vu un regain d'intérêt pour le cannabis thérapeutique à partir des années 1970, dans les suites notamment de la redécouverte sociale du cannabis au cours des années 1960 et des travaux qui ont permis d'isoler les composants actifs de la plante. De plus, en raison du nombre élevé d'allégations touchant les bienfaits thérapeutiques du produit, un nombre croissant de personnes ont demandé l'adoption d'une approche moins restrictive afin de permettre la vente du cannabis aux personnes qui pourraient tirer profit de cette utilisation.

Au Canada, aucun essai clinique démontrant sa sécurité et son efficacité n'ayant été fait, le cannabis ne peut pas être vendu comme produit médical.[1] Malgré cette interdiction, plusieurs consomment du cannabis à des fins thérapeutiques sans autorisation légale et divers organismes se sont établis qui à la fois distribuent du cannabis à des fins thérapeutiques et agissent comme groupe de pression au nom de ces patients.

---

[1] La vente de deux drogues commercialisées qui sont associées au cannabis a été autorisée au Canada : le Marinol, qui comprend du T.H.C. synthétisé par voie chimique, et le Cesamet, un cannabinoïde synthétique. Les deux peuvent être prescrits par les médecins.

Ce chapitre rappelle les événements qui ont mené à l'adoption récente de la *Réglementation sur l'accès à la marijuana à des fins médicales* qui vise à offrir un cadre d'accès humanitaire à la marijuana pour les Canadiens gravement malades, tout en poursuivant les recherches sur son utilisation à des fins thérapeutiques. Nous décrivons ensuite les dispositions de cette réglementation qui est entrée en vigueur le 30 juillet 2001. La dernière section examine sa mise en œuvre et s'interroge sur les limites intrinsèques à cette approche.

CADRE ENTOURANT LA RÉCENTE RÉGLEMENTATION

Article 56 – Loi réglementant certaines drogues et autres substances

La *Loi réglementant certaines drogues et autres substances*[2] interdit une série d'activités associées aux drogues psychoactives, dont la possession, la culture, le trafic, la possession à des fins de trafic, l'importation et l'exportation. Ces activités sont illégales, sauf si elles sont autorisées par les règlements de la Loi. Par exemple, les *Règlements sur les stupéfiants* régissent la distribution légale des stupéfiants.[3] De plus, avant de mettre en marché un médicament au Canada, la *Loi sur les aliments et drogues*[4] et ses règlements doivent en autoriser la vente. Les règlements de la Loi établissent, entre autres, les contrôles de la sécurité, de l'efficacité et de la qualité des produits thérapeutiques. Pour mettre en marché le cannabis sous la forme d'un médicament au Canada, le promoteur doit soumettre une «Présentation de drogue nouvelle» au Programme des produits thérapeutiques de Santé Canada. Les données fournies sont évaluées pour déterminer les bienfaits et les risques éventuels associés au médicament avant que sa vente soit autorisée.

D'autres mécanismes autorisent certaines activités habituellement interdites. Conformément à l'article 56 de la *Loi réglementant certaines drogues et autres substances*, le ministre de la Santé peut faire des exceptions si, selon lui, cette exception est nécessaire à des fins médicales ou scientifiques ou si elle est dans l'intérêt public. Dans ces circonstances précises, toute personne ou catégorie de personnes peut donc être exemptée de la mise en application d'une ou des dispositions de la Loi. Les activités comprennent la culture et la possession de marijuana, activités habituellement interdites par la Loi.

En réponse à la demande croissante pour permettre l'utilisation du cannabis à des fins thérapeutiques et pour éviter des contestations fondées sur la Charte relativement à l'usage thérapeutique, Santé Canada a publié un Document d'orientation provisoire en mai 1999. Ce document explique les étapes que les Canadiens doivent suivre pour faire

---

[2] C.S. 1996, chapitre 19.

[3] Ces drogues apparaissent dans l'Annexe et comprennent l'opium, la codéine, la morphine, l'héroïne, la cocaïne et le cannabis.

[4] S.R.C. 1985, chapitre F-27.

une demande d'exemption relativement à la possession et à la culture de la marijuana à des fins thérapeutiques, selon l'autorisation fournie dans l'article 56 de la Loi réglementant certaines drogues et autres substances. Les candidats doivent prouver que l'exemption est nécessaire à ces fins et doivent obtenir une note d'un médecin appuyant cette demande et comprenant les détails sur les antécédents médicaux et la pharmacothérapie du patient. Santé Canada revoit les demandes cas par cas, en tenant compte des besoins médicaux du patient. Les premières exemptions ont été accordées en juin 1999. Au 3 mai 2002, 658 exemptions avaient été autorisées, conformément à l'article 56 ; 501 d'entre elles sont toujours en vigueur. En ce qui concerne les autres 157 patients, certains ont l'autorisation de posséder du cannabis, conformément à la récente *Réglementation sur l'accès à la marijuana à des fins médicales*, tandis que d'autres n'ont peut-être plus besoin de consommer de la marijuana à des fins thérapeutiques. Pour se conformer au processus, les patients devaient limiter leur culture à la quantité indiquée dans leur lettre de dispense.[5]

Suite à son engagement de tenir une consultation publique sur le programme d'exemption de l'article 56, Santé Canada a organisé un atelier de consultations multilatérales en février 2000. Les participants[6] ont identifié les points prioritaires suivants :

- Obtenir une source de marijuana légale pour les personnes exemptées à l'article 56 ;
- Attribuer des exemptions pour les personnes soignantes ;
- Aborder le besoin de fournir de plus amples renseignements sur l'utilisation de la marijuana à des fins médicales ;
- Calmer les préoccupations des autorités policières ;
- Améliorer le processus et les outils associés aux demandes se conformant à l'article 56 ; et
- Diffuser des renseignements sur le processus prévu par l'article 56 et les activités de Santé Canada sur l'utilisation de la marijuana à des fins médicales[7].

Les renseignements recueillis lors de ces consultations ont été utilisés pour élaborer la *Réglementation sur l'accès à la marijuana à des fins médicales.*

---

[5] En juin 1999, Santé Canada a publié un rapport annonçant le lancement d'un plan de recherche sur l'utilisation de la marijuana à des fins thérapeutiques, et a indiqué que des mesures seront prises pour établir une source nationale de marijuana propre à la recherche. Nous discuterons de ces initiatives, de façon plus détaillée, dans des sections ultérieures du présent chapitre.

[6] Les participants sont des représentants des autorités policières, des médecins pratiquants, des chercheurs cliniques, de l'Association nationale des organismes de réglementation de la pharmacie, de Santé Canada et d'autres représentants dont l'affiliation est inconnue.

[7] Résumé de l'étude d'impact de la réglementation accompagnant la *Réglementation sur l'accès à la marijuana à des fins médicales*, page 17.

Contestations fondées sur la Charte – utilisation de la marijuana à des fins thérapeutiques[8]

Les tribunaux canadiens ont joué un rôle important pour obliger le gouvernement à réviser le processus d'exemption puisque diverses contestations de l'interdiction entourant l'usage de la marijuana à des fins thérapeutiques ont été couronnées de succès en vertu des libertés fondamentales inscrites dans la Charte.

Dans *Wakeford c. Canada* (1998),[9] une personne atteinte du SIDA qui consommait de la marijuana pour combattre ses nausées et sa perte d'appétit, effets secondaires des médicaments qu'elle prenait contre le SIDA, a demandé une exemption constitutionnelle à l'interdiction entourant la marijuana dans *la Loi réglementant certaines drogues et autres substances.* La Cour de l'Ontario (Division générale) a indiqué qu'en refusant à une personne de choisir elle-même le traitement de sa maladie, la loi brimait ses droits à la liberté et à la sécurité, tel que prévus par la Charte. La Cour a soutenu que l'interdiction de la marijuana n'était pas arbitraire, en autant que les risques de méfaits associés à la consommation pouvaient être établis.[10] En ce sens, dans son application générale, la Cour a trouvé que la loi respectait les principes de la justice fondamentale, tels qu'établis à l'article 7 de la Charte. Par contre, l'impact de la loi sur les consommateurs du cannabis à des fins médicales a soulevé d'autres questions et dans ce contexte, la Cour considérait que l'interdiction générale était trop vaste et que cette décision de l'état ne se justifiait pas aux motifs de la prohibition.

La Cour a déclaré qu'il serait contraire aux principes de justice fondamentale d'interdire la marijuana lorsqu'elle peut être un traitement médical significatif dans les cas de maladies débilitantes et mortelles et si aucun processus procédural ne permet d'obtenir une exemption aux poursuites.[11] Toutefois, la Cour a observé qu'un tel processus existe dans l'article 56 de la *Loi réglementant certaines drogues et autres substances.* En conséquence, la Cour a jugé que la Loi respectait les principes de justice fondamentale – même dans le cas des consommateurs à des fins médicales et elle a donc refusé de fournir une exemption constitutionnelle à M. Wakeford. Elle a mentionné que, sans un processus d'exemption ministérielle destiné aux consommateurs à des fins médicales, sa décision aurait été différente.[12] Plus tard, en raison de nouvelles preuves démontrant qu'aucun processus réel n'avait été établi pour traiter les demandes d'exemption en vertu de l'article 56 de la Loi, M. Wakeford a reçu une exemption constitutionnelle provisoire pour la possession et la production/culture de la marijuana. Jugeant l'exemption statutaire «illusoire », la Cour s'est penchée à nouveau sur le dossier et a accordé une exemption, qui devait demeurer en vigueur

[8] Cette section se fonde principalement sur la présentation « *La prohibition des drogues et la constitution* » au Comité sénatorial spécial sur les drogues illicites par David Goetz, Division du droit et du gouvernement, Direction de la recherche parlementaire, Bibliothèque du Parlement, 1er mars 2001.
[9] [1998] O.J. No. 3522 (Division générale - Ontario).
[10] *Ibid.*, aux parag. 49-50.
[11] *Ibid.*, au parag. 54.
[12] *Ibid.*, au parag. 66.

jusqu'à ce que le ministre de la Santé prenne une décision quant à la demande de M. Wakeford, conformément à l'article 56 de la Loi.[13]

Dans l'arrêt R. c. *Parker* (2000),[14] la Cour d'appel de l'Ontario est arrivée à une conclusion similaire relativement à l'impact de l'interdiction générale de la consommation de marijuana sur la «liberté et la sécurité » des consommateurs à des fins médicales. Dans ce cas, le patient – accusé de culture et de possession de marijuana – cultivait et consommait de la marijuana pour contrôler ses crises d'épilepsie. La Cour a décidé que la prohibition, au sens de la loi pénale, de la marijuana, *vis-à-vis* les consommateurs *de bonne foi* à des fins médicales, brimait leur droit à la liberté, conformément à l'article 7, en raison de la possibilité qu'ils soient emprisonnés. De plus, en empêchant les personnes de pouvoir choisir la marijuana comme médicament pour soulager les symptômes d'une maladie grave, l'interdiction brimait aussi les droits à la liberté et à la sécurité, sans égard à la possibilité qu'elles soient emprisonnées. Dans *Parker*, la Cour a aussi décidé que la prohibition générale de la possession de marijuana ne respectait pas les principes de justice fondamentale. La Cour d'appel s'est référée à la décision du juge de première instance en ce qui a trait aux troubles médicaux et aux symptômes sur lesquels le cannabis a un effet thérapeutique :

> [Traduction] *« En se fondant sur les preuves avancées lors du procès, le juge de première instance a décidé que la partie défenderesse a pu prouver que le fait de fumer de la marihuana a un effet thérapeutique sur les nausées et les vomissements, surtout pour le traitement des cas associés à la chimiothérapie, à la tension intra-oculaire provoquée par le glaucome, à la spasticité des muscles provoquée par des lésions à la moelle épinière ou la sclérose en plaques, aux migraines, aux crises d'épilepsie et aux douleurs chroniques. »* [15]

Nous notons en particulier que la Cour, dans *Parker*, est arrivée à la conclusion que le régime d'exceptions et exemptions prévu à la loi pour autoriser la consommation à des fins médicales était contraire aux principes de justice fondamentale. Premièrement, même si la loi, en théorie, mentionne qu'une personne pourrait obtenir de la marijuana sur ordonnance de médecin, les preuves présentées dans cette cause démontraient que : aucun pharmacien ne pouvait remettre un tel médicament ; le gouvernement n'approuverait aucun médecin qui prescrit de la marijuana ; et il était pratiquement impossible de trouver une source d'approvisionnement légale au Canada.[16] C'est pourquoi la Cour a indiqué que cette exception à la loi est illusoire.[17]

Deuxièmement, en ce qui a trait aux exemptions ministérielles prévues par l'article 56 de la *Loi réglementant certaines drogues et autres substances*, la Cour a conclu que cette procédure était inadéquate et ne respectait pas les principes de justice

---

[13] [1999] O.J. No. 1574, aux parag. 11, 31 et 32.

[14] 49 O.R. (3e) 481.

[15] *Ibid.*

[16] *Ibid.*, au parag. 155.

[17] *Ibid.*, au parag. 163.

fondamentale. La Cour a décidé que l'article 56 accordant les pleins pouvoirs au ministre de la Santé était une base inappropriée pour garantir la sécurité individuelle ou la liberté des personnes dans le contexte de l'accès à un traitement médical pour soulager les symptômes de maladies graves.[18] Les principaux points litigieux relatifs au processus d'exemption prévu par l'article 56 concernaient les pouvoirs du ministre prévus par la Loi, la transparence du processus, et une définition claire de la nécessité médicale.

La Cour est arrivée à la conclusion que l'interdiction générale de posséder de la marijuana était contraire à l'article 7 de la Charte et ne constituait pas une limite raisonnable et justifiable en vertu de l'article 1 de la Charte.[19] La Cour a donc déclaré l'interdiction de posséder de la marijuana inconstitutionnelle et sans force exécutoire. Par contre, la Cour a suspendu la déclaration d'invalidité pendant un an, afin que le Parlement puisse modifier la loi de façon à inclure des exemptions adéquates pour la consommation à des fns médicales. D'ici là, M. Parker détiendrait une exemption personnelle à l'interdiction de posséder de la marijuana. Dans l'arrêt *Parker*, la Cour a suggéré que sa décision relative au fait que l'interdiction de posséder de la marijuana violait l'article 7 de la Charte s'appliquerait probablement aussi à l'interdiction de cultiver.[20]

Réaction du gouvernement

En septembre 2000, alors qu'il songeait toujours à faire appel de la décision, le gouvernement a annoncé qu'il prévoyait adopter une nouvelle réglementation qui préciserait les circonstances permettant la consommation de marijuana à des fins thérapeutiques et les procédures d'autorisation.[21] Une *déclaration d'intention* a été publiée le 6 janvier 2001. Des réunions ont eu lieu avec des parties intervenantes clés identifiées par Santé Canada.[22]

En avril 2001, le gouvernement a annoncé les règlements proposés régissant la possession et la production de marijuana à des fins thérapeutiques. Ces règlements devaient répondre aux problèmes clés soulevés par la Cour d'appel de l'Ontario, relativement au processus d'exemption prévu par l'article 56. Ils comprennent deux composantes principales : 1) les autorisations permettant de posséder de la marijuana, et 2) les licences permettant de produire de la marijuana.

---

[18] *Ibid.*, aux parag. 184-185 et 188.

[19] *Ibid.*, aux parag. 191-194.

[20] *Ibid.*, au parag. 190.

[21] Santé Canada, communiqué de presse, « Le ministre Rock fait part de l'intention de mettre au point sous peu une nouvelle approche dans la réglementation de la consommation de marijuana à des fins médicinales », 14 septembre 2000.

[22] Les intervenants clés comprennent des représentants de l'Association médicale canadienne, de l'Association des pharmaciens du Canada, de la Société canadienne du sida, de la GRC, du ministère du Solliciteur général, du ministère de la Justice, de Service correctionnel du Canada et de l'Association canadienne des chefs de police.

Suite à la période de consultation de 30 jours, période durant laquelle Santé Canada a reçu des commentaires de 139 personnes et groupes, les changements suivants ont été apportés aux règlements proposés : le processus d'application serait géré par le requérant individuel plutôt que par le médecin ; les restrictions touchant les terres de production seraient moins sévères et ne comprendraient plus la limite de un kilomètre pour la culture à l'extérieur près des écoles et d'autres endroits fréquentés par des enfants ; la formule servant à calculer le nombre de plants permis par la licence de production serait rajustée pour refléter les récoltes à l'intérieur et à l'extérieur, ainsi que les marges d'erreur ; et des dispositions transitoires seraient comprises et toucheraient toutes les exemptions courantes dans un délai de six mois, pour que tous les patients puissent avoir l'occasion de se conformer aux nouveaux règlements.[23]

Le 4 juillet 2001, le gouvernement a annoncé que les règlements régissant la possession et la production de marijuana à des fins thérapeutiques entreraient en vigueur le 30 juillet 2001.

RÉGLEMENTATION SUR L'ACCÈS À LA MARIJUANA À DES FINS MÉDICALES

La *Réglementation sur l'accès à la marijuana à des fins médicales* comprend deux composantes principales : les autorisations permettant de posséder de la marijuana et les licences permettant de produire de la marijuana. Cette réglementation, a pour objectif d'offrir un cadre humanitaire pour l'accès à la marijuana à des fins médicales.

> *« La réglementation établit un cadre humanitaire qui permet aux personnes atteintes de maladies graves de consommer de la marijuana, lorsque les traitements conventionnels s'avèrent inappropriés ou n'offrent pas de soulagement adéquat aux symptômes associés à leur condition médicale ou à leur traitement, et lorsque la consommation de marijuana peut avoir un effet thérapeutique plus important que les risques qui y sont associés. »*[24]

Comme nous le verrons plus en détail, la réglementation ne prévoit l'accès à la marijuana que dans des circonstances spéciales, c'est-à-dire pour les conditions médicales graves pour lesquelles les traitements conventionnels ne soulagent pas adéquatement les symptômes. Selon Santé Canada, cette situation est attribuable « aux risques pour la santé associés au fait de fumer, en particulier, ce produit, et au manque de preuves appuyant les bienfaits prétendus ».[25]

---

[23] Santé Canada, Information, *Règlement sur l'accès à la marijuana à des fins médicales – modifications découlant des consultations publiques*, juillet 2001.

[24] Santé Canada, Information, *Accès à la marijuana à des fins médicales – fonctionnement de la réglementation*, juillet 2001.

[25] Résumé de l'étude d'impact de la réglementation accompagnant la *Réglementation sur l'accès à la marijuana à des fins médicales*, page 8.

Notons aussi que l'application de la réglementation est limitée au « cannabis (marijuana) », tel qu'apparaissant dans le sous-article 1(2) de l'Annexe II de la *Loi réglementant certaines drogues et autres substances* ; autrement dit, la réglementation ne s'applique pas aux dérivés du cannabis (le haschich par exemple).

Autorisation de posséder

Trois catégories distinctes d'autorisations de posséder de la marijuana séchée ont été crées, chacune comportant ses propres conditions de demande. Dans chaque cas, la demande doit être faite par le patient. La déclaration doit comprendre des renseignements identifiant le demandeur et indiquant si :

- Le demandeur sait qu'aucun avis de conformité n'a été soumis, conformément à la *Loi sur les aliments et drogues*, relativement à la sécurité et à l'efficacité de la marijuana en tant que médicament, et s'il comprend la signification de ce fait ; et
- Le demandeur a discuté des risques associés à la consommation de la marijuana avec un médecin et il accepte de la consommer aux fins médicales recommandées.

Catégorie 1

- Admissibilité : Cette catégorie touche les demandeurs souffrant de symptômes associés à une maladie et **dont on prévoit la mort dans un délai de douze mois**.
- Conditions : Un **médecin** doit fournir une déclaration médicale qui indique :
  - La condition médicale du patient et les symptômes associés à cette condition ou à son traitement ;
  - Que le patient est atteint d'une maladie en phase terminale ;
  - Que le patient a essayé ou envisagé tous les traitements conventionnels pour les symptômes présents ;
  - Que la consommation recommandée de marijuana atténuerait les symptômes ;
  - Que les avantages de la consommation recommandée de marijuana excéderaient les risques associés à cette consommation ;
  - Que le médecin sait qu'aucun avis de conformité n'a été soumis, conformément à la *Loi sur les aliments et drogues*, relativement à la sécurité et à l'efficacité de la marijuana en tant que médicament ; et
  - La dose quotidienne recommandée et la durée du traitement.

Catégorie 2

❖ Admissibilité : Cette catégorie vise les demandeurs qui souffrent de symptômes particuliers associés à certains troubles médicaux graves, notamment :

- **Sclérose en plaques** : douleur grave et/ou spasmes musculaires persistants ;
- **Lésion de la moelle épinière** : douleur grave et/ou spasmes musculaires persistants ;
- **Maladie de la moelle épinière** : douleur grave et/ou spasmes musculaires persistants ;
- **Cancer** : douleur grave, cachexie, anorexie, perte de poids et/ou nausées;
- **Sida/infection au VIH** : douleur grave, cachexie, anorexie, perte de poids et/ou nausées ;
- Formes graves d'**arthrite** : douleur intense ; et
- **Épilepsie** : crises d'épilepsie.[26]

	Douleur aiguë	Spasmes musculaires persistants	Cachexie	Anorexie	Perte de poids	Nausée violente	Convul-sions
Sclérose en plaques							
Lésion de la moelle épinière							
Maladie de la moelle épinière							
Cancer							
SIDA, infection au VIH							
Forme grave d'arthrite							
Épilepsie							

Source : Demande d'autorisation de possession de marijuana séchée, Catégorie 2 – Formulaire du médecin spécialiste.

❖ Conditions : Les demandeurs doivent fournir une déclaration d'un **médecin spécialiste** pour étoffer leur demande. La déclaration doit confirmer :

- La condition médicale du patient et les symptômes associés à cette condition ou à son traitement ;

[26] Ces symptômes apparaissent dans une annexe de la Réglementation sur l'accès à la marijuana à des fins médicales et ont été choisis en se fondant sur les résultats ou les conclusions de rapports scientifiques et médicaux, même si les crises associées à l'épilepsie ont été ajoutées suite à la décision dans la cause *Parker*. Cette liste doit être revue régulièrement et devra être modifiée dès que de nouveaux renseignements sont rendus publics.

- Que le médecin spécialiste œuvre dans un domaine de la médecine connexe au traitement de la condition médicale du patient ;
- Que le patient a essayé ou envisagé tous les traitements conventionnels pour les symptômes présents et que ces traitements se sont avérés inappropriés médicalement, conformément aux raisons indiquées dans la réglementation ;
- Que la consommation recommandée de marijuana atténuerait les symptômes ;
- Que les bienfaits de la consommation recommandée de marijuana excéderaient les risques associés à cette consommation, y compris les risques associés à la consommation à long terme de la marijuana ;
- Que le médecin spécialiste sait qu'aucun avis de conformité n'a été soumis, conformément à la *Loi sur les aliments et drogues*, relativement à la sécurité et à l'efficacité de la marijuana en tant que médicament ; et
- La dose quotidienne recommandée et la durée du traitement.

Catégorie 3

- ❖ Admissibilité : Cette catégorie vise les demandeurs qui présentent des symptômes **autres que ceux décrits dans les catégories 1 et 2.**
- ❖ Conditions : Des déclarations de **deux médecins spécialistes** doivent accompagner la demande. La première déclaration doit indiquer : tous les points apparaissant dans la Catégorie 2 ; tous les traitements conventionnels pour les symptômes qui ont été essayés ou envisagés ; et les raisons, parmi celles indiquées dans la réglementation, pour lesquelles le spécialiste juge que ces traitements sont inappropriés médicalement.

SYMPTÔME(S)	**TRAITEMENTS**	**RAISONS** – Pour chaque traitement conventionnel indiqué dans la colonne des « Traitements », veuillez indiquer les raisons pour lesquelles vous considérez que le traitement est médicalement inapproprié. **(MARQUER LA BOÎTE APPROPRIÉE CI-DESSOUS)**							
Dans cette colonne, veuillez donner la liste de(s) symptôme(s) associés à l'état pathologique ou à son traitement et sur lesquel(s) la demande d'autorisation est fondée.	Dans cette colonne, pour chaque symptôme, veuillez donner la liste des traitements conventionnels qui ont été administrés ou envisagés.	Le traitement s'est révélé inefficace.	Il y a eu une réaction allergique à la drogue administrée comme traitement.	Il existe, pour lui, un risque de sensibilisation croisée à une drogue de même type.	Le demandeur a eu une réaction indésirable à la drogue administrée comme traitement.	Il existe, pour lui, un risque de réaction indésirable à la drogue du fait de réactions antérieures similaires observées chez lui lors de l'administration d'une drogue de même type.	La drogue administrée comme traitement a provoqué, chez le demandeur, une interaction médicamenteuse néfaste ou il existe, pour lui, un risque d'une telle interaction.	La drogue administrée comme traitement est contre-indiquée.	La drogue envisagée comme traitement possède une structure chimique et une activité pharmacologique similaires à celles d'une autre drogue qui s'est révélée inefficace pour le demandeur.

Source : Demande d'autorisation de possession de marijuana séchée, Catégorie 3 – Formulaire du premier médecin spécialiste

- La deuxième déclaration doit mentionner, entre autre : que le spécialiste a revu le dossier médical du patient et les raisons expliquant pourquoi les traitements conventionnels sont considérés comme étant inappropriés médicalement ; que le spécialiste a discuté du dossier du patient avec le premier spécialiste et croit que la consommation recommandée de la marijuana atténuerait les symptômes, et que les bienfaits de la consommation recommandée de marijuana excéderaient les risques associés à cette consommation, y compris les risques associés à la consommation à long terme de la marijuana ; et que le second spécialiste sait qu'aucun avis de conformité n'a été soumis, conformément à la *Loi sur les aliments et drogues*, relativement à la sécurité et à l'efficacité de la marijuana en tant que médicament.

Posologie

Le médecin ou le spécialiste décide de la dose quotidienne. Si la dose quotidienne recommandée dépasse 5 grammes par jour, le médecin ou le spécialiste doit indiquer s'il a tenu compte des risques associés à une dose quotidienne élevée de marijuana, y compris les effets sur les systèmes cardiovasculaire, pulmonaire et immunitaire, sur la performance psychomotrice du patient, ainsi que la dépendance possible à la drogue ; et que, selon son opinion médicale, les avantages qu'offre la consommation de marijuana, selon la dose quotidienne recommandée, excéderaient les risques associés à cette dose, y compris les risques associés à la consommation à long terme de la marijuana.

Quantité maximale qu'on peut posséder

L'autorisation de posséder précise qu'on peut posséder, en tout temps, une quantité équivalant à un traitement de 30 jours. Tel qu'expliqué ci-dessus, le médecin ou le spécialiste fixe une dose quotidienne utilisée pour déterminer la quantité du traitement de 30 jours.

Durée

En général, les autorisations de posséder sont valables durant un an et peuvent être renouvelées.

Licences de production

Présentement, il existe deux sources d'approvisionnement légal pour les détenteurs d'une autorisation de posséder : ils peuvent produire leur propre culture ou demander à quelqu'un de le faire pour eux. Santé Canada a indiqué que, dans un avenir rapproché, ils pourront s'approvisionner auprès d'un fournisseur autorisé.

Seuls les détenteurs d'une autorisation de posséder (licence de production de marijuana par le demandeur) ou les personnes qui les représentent (licence de production de marijuana par une personne désignée) peuvent obtenir une licence de

production. Les personnes désignées ne peuvent pas être rémunérées pour leurs activités.

Les conditions qu'il faut respecter pour obtenir une licence de production sont :

- Une personne ne peut pas détenir plus d'une licence de production ;
- Un emplacement peut être utilisé pour la production de marijuana, pour un maximum de trois licences différentes ;
- Le titulaire d'une licence de production doit adopter des mesures nécessaires pour assurer la sécurité du produit ;
- La production de marijuana à l'extérieur est interdite si le site de production est situé à côté d'une école, d'un terrain de jeux public, d'une garderie ou d'un autre endroit public fréquenté principalement par des mineurs ; et
- Une personne ne peut pas obtenir de licence de production par une personne désignée si elle a été trouvée coupable d'une infraction désignée en matière de drogues au cours des 10 années précédentes.

La licence précise le nombre maximal de plants qui peuvent être cultivés. La licence indique aussi la quantité maximale de marijuana séchée qu'on peut stocker et, dans le cas d'une personne désignée, qu'on peut transporter. La quantité maximale de marijuana qu'on peut cultiver et stocker, en tout temps, varie selon la dose quotidienne prescrite par le médecin ou le spécialiste, et selon le fait que les plants sont produits à l'intérieur ou à l'extérieur. La réglementation porte aussi sur les pouvoirs d'inspection et les exigences relatives à la tenue de registres.

Autres dispositions

D'autres dispositions traitent de sujets tels : les mesures pour assurer la sécurité de la marijuana que possède la personne autorisée ; la révocation des licences ; la présentation de documents aux policiers ; la présentation de plaintes reçues par les inspecteurs aux autorités policières ; et la diffusion de renseignements sur un médecin aux services provinciaux chargés d'accorder des licences aux médecins. Une disposition transitoire prolonge les exemptions à l'article 56 de six mois après la date d'expiration.

Santé Canada a établi un processus de révision permanent pour surveiller l'efficacité et l'application de la réglementation, et émettre des avis sur les mesures futures relatives à la fabrication, à la distribution et à la vente de la marijuana à des fins médicales. Ce processus prévoit une série d'activités permettant de recueillir des renseignements et d'obtenir des commentaires sur divers aspects de la réglementation. Un comité de 15 membres composé de divers groupes intéressés par la question est en création ; sa première réunion est prévue pour octobre 2002.

ACCÈS HUMANITAIRE ?

La Réglementation sur l'accès à la marijuana à des fins médicales se veut un cadre d'accès humanitaire à la marijuana reposant sur le principe qu'on « ne doit pas restreindre, de façon inutile, la disponibilité de la marijuana pour les patients qui pourraient tirer profit de ses bienfaits ».[27]

Mais le processus autorisant la possession et la production de marijuana à des fins médicales ne garantit pas que le cannabis est effectivement rendu disponible aux personnes qui en ont besoin. En fait, notre examen de la réglementation et des preuves qui nous ont été remises nous a convaincus que la réglementation représente un obstacle à l'accès. Plutôt que d'être un cadre humanitaire, la réglementation restreint de façon inutile la disponibilité du cannabis pour ceux qui pourraient en retirer des bienfaits.

L'énoncé de l'analyse d'impacts accompagnant la réglementation, disait notamment ceci :

> *« En raison de l'augmentation de la visibilité et de l'efficacité prévues du nouveau cadre réglementaire et de la sensibilisation accrue envers la consommation éventuelle ou les bienfaits médicaux de la marijuana, on peut, de façon raisonnable, s'attendre à ce que le nombre de demandes* **augmente de façon importante.** *» (Nous soulignons.)*

Comme nous l'avons mentionné plus haut, 658 exemptions avaient été accordées en vertu de l'article 56 et 501 exemptions étaient toujours en vigueur. Le 3 mai 2002, Santé Canada nous a informé que 498 demandes avaient été reçues en vertu de la Réglementation sur l'accès à la marijuana à des fins médicales, et 255 autorisations accordées. De plus, 164 licences de production individuelles et 11 licences de production par une personne désignée avaient été octroyées. Les autres dossiers étaient toujours incomplets, exigeant de plus amples renseignements, ou attendant d'être évalués.[28]

Autrement dit, presque un an après l'entrée en vigueur de la réglementation, seulement 255 personnes avaient reçu une autorisation de posséder de la marijuana à des fins thérapeutiques sur les 498 demandes reçues. Ce nombre est beaucoup moins élevé que le nombre d'exemptions accordées conformément à l'article 56 de la *Loi réglementant certaines drogues et autres substances.* Même si, conformément à l'article 56, 501 exemptions sont toujours en vigueur, il est clair que le nombre de demandeurs en vertu de la réglementation n'a pas augmenté de façon importante, tel qu'il avait été raisonnablement prévu. En fait, nous doutons de l'efficacité du nouveau cadre

---

[27] Résumé de l'étude d'impact de la réglementation accompagnant la *Réglementation sur l'accès à la marijuana à des fins médicales*, page 13.

[28] Gillian Lynch, directrice générale, Programme de la stratégie antidrogue et des substances contrôlées, Santé Canada, Délibérations du Comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001-2002, numéro 22, page 32.

réglementaire. À lui seul, le petit nombre de demandes soulève de nombreuses questions chez tous ceux qui désirent sincèrement offrir un accès humanitaire au cannabis à des fins thérapeutiques. Les sections suivantes discutent de certaines questions précises auxquelles il faudra répondre si on veut rendre le cadre réglementaire réellement efficace et humanitaire.

Admissibilité

Selon la réglementation actuelle, les demandeurs doivent obtenir une déclaration d'un médecin (ou de un ou deux spécialistes) indiquant que la consommation recommandée de marijuana atténuerait leurs symptômes **et** que les bienfaits de la consommation recommandée de marijuana excéderaient les risques associés à cette consommation. Le médecin doit aussi déterminer la posologie quotidienne du demandeur et la durée du traitement. Médecin est défini comme toute personne qui peut, selon la loi provinciale, pratiquer la médecine.

Tous les intervenants ont observé que le fait de demander aux médecins de jouer le rôle de «gardiens » de la marijuana à des fins thérapeutiques a créé un obstacle majeur à l'accès et que, comme l'indique Santé Canada, «il y a là la quadrature du cercle ». L'Association médicale canadienne et plusieurs autres organismes médicaux professionnels ont refusé d'appuyer le nouveau processus d'application fédéral, en raison de problèmes touchant la sécurité des patients, la posologie et la responsabilité légale des médecins prescrivant du cannabis.

Ces réserves n'auraient pas dû surprendre Santé Canada puisqu'au cours des consultations sur les règlements proposés deux associations médicales et deux services provinciaux d'émission de permis de pratique médicale s'étaient opposés à la consommation de marijuana fumée à des fins médicales, invoquant notamment :

- Le manque de preuves scientifiques justifiant la consommation ;
- Le fait que la marijuana n'est pas un médicament approuvé ;
- Le point de vue selon lequel la consommation de marijuana fumée n'est pas un mode acceptable d'administration d'un médicament ; et
- Le point de vue selon lequel la responsabilité attribuée aux médecins pour la consommation de marijuana à des fins médicales pourrait créer un conflit avec le code d'éthique professionnel, relativement à l'utilisation de traitements non approuvés ou de médecines « douces ».[29]

La position adoptée par l'Association canadienne de protection médicale (ACPM) reflète bien les positions adoptées par d'autres personnes et organismes de la communauté médicale. L'Association canadienne de protection médicale est une mutuelle de protection des médecins qui compte 60 000 membres soit environ 95 %

[29] Résumé de l'étude d'impact de la réglementation accompagnant la *Réglementation sur l'accès à la marijuana à des fins médicales*, page 19.

des médecins en exercice au Canada. Elle a averti ses membres qu'ils pourraient s'exposer à des plaintes touchant leur responsabilité et des fautes professionnelles s'ils prescrivaient de la marijuana sans connaître, de façon détaillée, les risques et les bienfaits de la drogue, ainsi que la posologie appropriée. Un feuillet d'information distribué aux membres soulignait entre autres ce qui suit :

> *« L'Article 69 du Règlement prévoit qu'une autorité chargée de délivrer les permis d'exercice de la médecine peut demander au ministre fédéral de la Santé des renseignements au sujet d'un médecin et que le ministre peut fournir ces renseignements s'il a des motifs raisonnables de croire que le médecin en question a fait de fausses déclarations en application des dispositions prévues au Règlement. Cet article du Règlement est source d'importantes préoccupations, étant donné que les médecins peuvent, à leur insu, faire de fausses déclarations s'ils sont appelés à attester des faits pouvant dépasser l'étendue de leur expertise. Il y a donc augmentation du risque qu'une plainte soit déposée contre eux auprès de leur collège.*
>
> *La marijuana n'étant pas un médicament approuvé, certains pourraient croire qu'il s'agit d'une médecine douce. Cela soulève la question importante à savoir si les Collèges obligeraient les médecins qui aident leurs patients à remplir une demande d'autorisation de possession de marijuana à se conformer à leur politique en matière de médecines douces ou parallèles. L'ACPM recommande aux médecins de se renseigner auprès de leur organisme de réglementation professionnelle pour connaître leur position à cet égard.*
>
> *Compte tenu des conséquences que peuvent subir les médecins qui dérogent à la politique de leur organisme de réglementation professionnelle ou de la possibilité que leur responsabilité médico-légale soit mise en cause, il est recommandé que les médecins fassent preuve de prudence lorsqu'ils déterminent s'il y a lieu d'aider un patient à présenter une demande d'autorisation de possession de marijuana en vertu de ce règlement. »*[30]

L'ACPM a aussi indiqué que les renseignements sur l'efficacité de la marijuana à des fins médicales pour chaque patient, les risques et les bienfaits relatifs de la drogue et la posologie appropriée ne sont pas disponibles. La majorité des médecins ne peuvent donc pas respecter les conditions de la Réglementation sur l'accès à la marijuana à des fins médicales. Selon l'association, la réglementation impose « une responsabilité inacceptable aux médecins membres ». De plus, elle a indiqué que, «puisque plusieurs médecins ne connaissent pas l'efficacité, les risques et les bienfaits de la marijuana, nous croyons qu'il n'est pas raisonnable d'attribuer un rôle de gardien aux médecins».[31] L'ACPM a conseillé à ses membres :

> *« Dans le Feuillet d'information ci-annexé, qui a déjà été distribué à nos membres, nous recommandons aux médecins qui sont saisis d'une demande d'accès à la marijuana à des fins médicales de la part d'un patient de s'abstenir de signer le formulaire de déclaration à l'appui de cette demande s'ils n'ont pas ou*

---

[30] Association canadienne de protection médicale, *Ce qu'il faut faire lorsque vos patients présentent une demande d'autorisation de possession de marijuana à des fins médicales*, octobre 2001.

[31] Association canadienne de protection médicale, lettre à l'Honorable Allan Rock, c.r., 8 novembre 2001.

estiment ne pas avoir les qualifications requises pour effectuer l'évaluation préalable à la déclaration. Nous leur conseillons en outre d'expliquer à leurs patients les raisons pour lesquelles ils ne peuvent émettre cette déclaration et, le cas échéant, d'orienter ces patients vers d'autres médecins ayant plus d'expérience dans la prescription de marihuana à des fins thérapeutiques.

Enfin, puisque certains médecins, par compassion pour un patient, peuvent croire de bonne foi que celui-ci pourrait bénéficier des bienfaits de la marihuana sur le plan médical, nous leur recommandons de remplir uniquement les parties 1 et 2 du formulaire de déclaration et de NE PAS remplir les parties 3, 4 et 5, laissant ainsi à la discrétion de Santé Canada la décision de traiter ou non une demande incomplète. » [32]

Il est évident que, dans ces circonstances, les patients auront de la difficulté à trouver un médecin qui acceptera de remplir les formulaires de déclaration nécessaires, et encore plus de difficulté à trouver les spécialistes appropriés. Cette situation crée un obstacle inacceptable à l'accès. Il faut en conclure que les médecins ne doivent pas devenir les gardiens de la Réglementation, une responsabilité qu'ils ne désirent pas prendre. Même Santé Canada reconnaît qu'il existe un problème.

« Sans preuve scientifique, les médecins font face à un dilemme juridique. Dans le cas des autres produits thérapeutiques, les médecins se fient aux renseignements que Santé Canada diffuse ou analyse par l'entremise du processus d'examen des médicaments. Ce sont des renseignements de base sur lesquels les médecins se fondent pour comprendre les produits. Dans ce cas-ci, aucune analyse n'existe.
Grâce à la Réglementation sur l'accès à la marijuana à des fins médicales, nous avons éliminé l'élément criminel associé à la possession et à la culture pour vos besoins propres. C'est le cadre réglementaire en place. Nous travaillons avec Prairie Plant Systems, tel que l'a mentionné M^me^ Lynch, pour élaborer une source de marijuana propre à la recherche qui sera offerte lors d'essais cliniques légitimes auprès de patients.

D'ici là, alors que nous commencerons à obtenir les résultats de la recherche et que la communauté médicale déterminera si elle prescrira ce produit dans des circonstances légitimes, il existe un problème. » [33]

Nous ne remettons pas en question le fait que le corps médical doive être impliqué dans le processus. Mais il faut déterminer avec précision le rôle du médecin en ce qui a trait à la consommation de cannabis à des fins thérapeutiques. Les médecins sont formés pour diagnostiquer la condition médicale d'un patient et les symptômes qui y sont associés, et pour déterminer le traitement médical de cette condition et des symptômes. Par contre, la majorité des médecins n'ont pas de connaissances suffisantes quant aux bienfaits thérapeutiques du cannabis et hésitent à prescrire ce produit pour différentes raisons, dont son illégalité. Selon nous, et comme

---

[32] *Ibid.*

[33] Dann Nichols, sous-ministre adjoint, Direction générale de la Santé environnementale et sécurité des consommateurs, Santé Canada, Délibérations du Comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001-2002, numéro 22, pages 37-38.

nous l'avons expliqué en détail dans le chapitre 9, une distinction s'impose entre un médicament approuvé et une drogue qui peut avoir des effets thérapeutiques – même si ces effets n'ont pas encore été confirmés « scientifiquement ». Le chapitre 9 énumère les conditions et les symptômes pour lesquels le cannabis peut avoir un effet thérapeutique. Soyons clairs. Nous ne croyons pas que le cannabis est une drogue miraculeuse qui traitera ou guérira plusieurs conditions médicales et symptômes. Par contre, c'est une drogue qui, on le sait, peut offrir un soulagement efficace de certaines conditions médicales et symptômes, améliorant ainsi la qualité de vie de plusieurs personnes.

Dans ces circonstances, le rôle du médecin est de poser un diagnostic de la condition médicale et des symptômes du patient. Lorsque le diagnostic identifie l'une des conditions médicales pour lesquelles le cannabis *peut* avoir un effet thérapeutique, le patient serait autorisé à consommer le produit thérapeutique de son choix, dont le cannabis. Par voie de conséquence, il faudrait aussi abolir l'exigence selon laquelle tous les autres traitements conventionnels doivent avoir été essayés ou envisagés, pour que la consommation de cannabis soit autorisée. Il n'existe aucune justification expliquant pourquoi le cannabis doit être un traitement de dernier recours.

Par ailleurs, l'exigence selon laquelle un spécialiste doit être impliqué peut clairement entraîner des délais systématiques et longs. Pire encore, les positions des organismes médicaux rendent très difficile l'obtention de déclarations de deux spécialistes. Cette situation crée un autre obstacle injustifié.

> *« L'exigence selon laquelle il faut impliquer un médecin spécialiste pour autoriser la possession de cannabis à des fins médicales est injustifiée, infondée, irréaliste et répressive. Elle annule la rapidité de l'accès et impose une charge injustifiée au patient ainsi qu'au système de soins de santé. Plusieurs patients attendent déjà pendant 9 à 12 mois avant de consulter un spécialiste. Cela signifie que les personnes qui attendent d'obtenir l'autorisation de posséder du cannabis à des fins médicales peuvent attendre pendant plus de un an. C'est une attente inhumaine pour ceux qui ont des besoins médicaux urgents. De plus, cela allongera, de façon inutile, les listes d'attente déjà longues des spécialistes. Les personnes qui doivent consulter réellement un spécialiste souffriront inutilement. »*[34]

Le chapitre 9 identifie les conditions et les symptômes pour lesquels le cannabis pourrait être autorisé. De nouveaux symptômes ou conditions pourront être ajoutés, suite à des recherches continues.

Nous savons que, selon la *Convention unique sur les stupéfiants* de 1961, une ordonnance médicale semble nécessaire pour fournir ou remettre une drogue visée aux annexes de la Convention.[35] À ce sujet nous faisons deux observations :

- Les conventions internationales sont assujetties aux dispositions constitutionnelles d'un pays. Or nous avons vu que les tribunaux

---

[34] B.C. Compassion Club Society, *BCCCS Response to Health Canada's Proposed Medical Marijuana Access Regulations*, 4 mai 2001, page 4.

[35] *Convention unique sur les stupéfiants, 1961*, Article 30.2.b.i.

canadiens ont décidé que le fait d'empêcher une personne de choisir la marijuana comme médicament pour atténuer les effets d'une maladie grave viole les droits de la *Charte canadienne des droits et libertés*, sauf si un cadre d'exemption statutaire permet une telle consommation. Les tribunaux ont indiqué que, lorsqu'un cadre d'exemption statutaire est « illusoire », une exemption constitutionnelle sera accordée. Les positions adoptées par les organismes médicaux au Canada peuvent rendre le cadre d'exemption de la Réglementation sur l'accès à la marijuana à des fins médicales « illusoire ».

- Il convient de s'en tenir à l'esprit plutôt qu'à la lettre de la Convention. Bien que le cannabis ne soit pas un médicament approuvé conformément aux processus traditionnels de recherche clinique, on ne peut pas mettre en doute ses effets thérapeutiques possibles. C'est pourquoi le Gouvernement du Canada devrait informer la communauté internationale qu'il ne respectera pas cette exigence à la lettre et demandera que des modifications appropriées soient apportées aux conventions internationales.

Accès au cannabis

La capacité des patients de cultiver leur propre marijuana ou de trouver une personne acceptant de le faire à leur place a aussi fait l'objet de vives préoccupations. Ce problème est aggravé par la condition voulant qu'une personne ne puisse pas détenir plus d'une licence de production. Les problèmes associés au cadre réglementaires incluent : un manque d'expérience quant à la culture, des produits de qualité et de puissances inconnues, les risques associés à la sécurité lors de la culture de la marijuana; etc.

Il ne fait aucun doute que les patients doivent avoir accès à du cannabis sécuritaire et de qualité élevée. L'option de culture individuelle devrait continuer d'être offerte à ceux qui le désirent. Dans de tels cas, le patient s'inscrirait directement auprès de Santé Canada. Dans les cas où la culture individuelle s'avère inappropriée ou impossible, un accès devrait être autorisé, par l'entremise des **Centres de distribution spécialisés dans le cannabis**. Dotés d'un personnel connaissant les applications thérapeutiques du cannabis, ces centres seraient en mesure d'informer les patients sur la posologie, la souche et la puissance les mieux adaptées à leurs conditions. La mise en place de centres de distribution responsables de l'approvisionnement en cannabis de qualité élevée se justifie d'autant plus que, malgré les annonces faites, le Canada n'a toujours pas réussi à créer une source domestique fiable de marijuana pour la recherche. De plus, nous sommes convaincus que le gouvernement ne doit pas être le seul distributeur de cannabis à des fins thérapeutiques. Présentement, les clubs de compassion jouent un rôle très important auprès de ceux qui ont besoin de cannabis à des fins thérapeutiques. Par exemple, la *B.C. Compassion Club Society* est un organisme enregistré sans but lucratif qui distribue du cannabis à des fins médicales depuis 1997. Il compte 28 employés et dessert environ 1600 membres. Avant d'accepter un membre, le club exige une confirmation du diagnostic et une recommandation du médecin, du naturopathe ou du psychiatre. Si le médecin refuse de signer la recommandation parce qu'il est hésitant face au statut juridique du cannabis, ou éprouve des préoccupations quant aux peines pouvant en découler, le club accepte le patient sans la recommandation du médecin, selon la gravité du cas. Des clubs de compassion semblables existent ailleurs au Canada.[36]

Le fait d'avoir accès à différentes souches de cannabis ayant divers niveaux de puissance s'avère crucial. Par exemple, le *B.C. Compassion Club Society* stocke, présentement, plusieurs variétés de cannabis.

> *« Notre stock quotidien comprend, habituellement, de sept à dix variétés de cannabis, une ou deux variétés de haschich, de la teinture de cannabis et des produits de boulangerie. Il est important que les consommateurs de marijuana à des fins médicales aient accès à plusieurs souches, car l'effet du cannabis*

[36] Par exemple, la Vancouver Island Compassion Society compte présentement 235 membres, et le Club de compassion de Montréal compte 130 membres.

varie selon la souche utilisée et la méthode d'ingestion. Nous mentionnons les différences à nos membres, qui peuvent choisir la meilleure souche de cannabis pour traiter efficacement leurs symptômes. »[37]

Des tests rigoureux pourraient assurer la distribution de produits de qualité élevée. L'importance des tests est l'un des problèmes clés.

« *Pour ce qui est des développements sur lesquels nous travaillons et désirons continuer à travailler, il est absolument crucial d'établir des lignes directrices strictes quant à la moisissure et au mildiou, aux pesticides, aux fongicides, aux métaux lourds et les types d'éléments – qui peuvent être dangereux – qu'on peut trouver dans le cannabis non organique. Même dans le cannabis organique, certains de ces éléments en microbiologie peuvent être dangereux pour les gens, surtout les gens dont le système immunitaire est affaibli. Nous ne pourrons établir ces normes que lorsque la communauté médicale responsable des recherches sur la marijuana aura accès aux laboratoires. Je crois que nous pouvons établir plusieurs types de normes quant à la sécurité et à la propreté associées à la culture et à la distribution.*»[38]

Malgré que tous s'entendent pour dire que leurs motifs pour distribuer du cannabis à des patients afin d'atténuer leurs souffrances sont louables, la plupart des clubs existants ont eu, et ont encore souvent, des problèmes juridiques. Fonctionnant dans une « zone grise », les personnes œuvrant dans ces clubs peuvent faire face ou font face à des poursuites. Par exemple, Philippe Lucas, le directeur de la *Vancouver Island Compassion Society* (VICS), a été arrêté et accusé de possession à des fins de trafic dans le cadre de son travail à la VICS. M. Lucas a plaidé coupable à l'accusation, mais a récemment reçu une absolution inconditionnelle. Certains commentaires du juge qui a prononcé la sentence sont pertinents à nos discussions. À propos de la question de l'admissibilité, le juge a indiqué :

[Traduction] « *On peut juger la présente cause dans un contexte vaste, pour lequel, jusqu'ici, les règlements fédéraux et la position du Collège des médecins ont rendu extrêmement difficile l'obtention d'une autorisation pour consommer de la marijuana.* »[39]

Il a ajouté ce qui suit sur l'accès à la marijuana :

[Traduction] « *De plus, le gouvernement fédéral a, jusqu'ici, été incapable d'offrir une source légale de marijuana aux personnes qui, selon Santé Canada, ont besoin du produit à des fins thérapeutiques. La situation est particulièrement complexe pour celles qui ne peuvent pas cultiver le produit.*

---

[37] Délibérations du Comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001, numéro 10, page 36

[38] *Ibid.*, page 44.

[39] R. c. *Lucas*, cour provinciale de la Colombie-Britannique, Victoria, dossier : 113701C, para. 47 (Honorable Juge Higinbotham).

…la Couronne ne peut pas utiliser l'argument selon lequel il existe une option légitime pour ceux qui ont besoin de la drogue, lorsque les preuves montrent bien que la drogue n'est, qu'en théorie, offerte par des sources légales. »[40]

En conclusion, le juge a indiqué :

[Traduction] *« J'arrive à la conclusion que, même si M. Lucas a contrevenu à la loi en proposant du cannabis à d'autres personnes, ses actions servaient à améliorer le sort de personnes souffrantes. Sa conduite a amélioré le sort d'autres personnes. Selon l'analyse de la cour, M. Lucas a amélioré la qualité de vie d'autres personnes avec peu ou pas de risques pour la société, même s'il agissait illégalement. Il a prouvé que le gouvernement est incapable d'offrir un approvisionnement en marijuana sécuritaire et de qualité élevée aux personnes qui en ont besoin à des fins médicales. Il a agi ouvertement, en adoptant des mesures de protection raisonnables. Il a montré la sincérité de ses principes en déclarant qu'il poursuivra ses activités. De plus, la situation montre bien que la société doit régler rapidement ce problème épineux, que ce soit au Parlement ou à la Cour suprême du Canada. S'il est de nouveau accusé, il devra faire valoir encore une fois son point de vue et ne sera peut-être pas absous. La cour espère que l'intelligence primera jusqu'à la résolution finale du problème de consommation de marijuana à des fins médicales et non médicales. »*[41]

À Montréal, deux bénévoles du Club Compassion ont été arrêté 3 mois après le début de leurs activités. Une décision devrait être prise à la fin du mois d'août 2002. Il est par ailleurs encourageant de noter que, Hilary Black, fondatrice et directrice de la *B.C. Compassion Club Society*, a déclaré que les autorités policières ont généralement appuyé le travail de son organisme. Par contre, son expérience révèle les limites et les contradictions de la situation qui prévaut encore actuellement.

« Les policiers qui sont venus au club de compassion m'ont dit à quel point nous faisions du bon travail. Ils ont même, à une occasion, protégé un coffre rempli de cannabis pour nous. Par contre, un policier a déjà tenu une arme pointée sur ma tête parce que je me trouvais dans un site de culture. Pendant que je rencontrais le ministre fédéral de la Santé, Alan Rock, pour lui fournir des recommandations et des renseignements demandés par Santé Canada, la GRC a démantelé une serre qui cultivait du cannabis organique à faible coût pour la Compassion Club Society. Pendant que je discute avec vous, que je partage nos renseignements en tant qu'experts en distribution de cannabis à des fins médicales, mes collègues peuvent être arrêtés, emprisonnés, empêchés de voyager, de travailler et de distribuer du cannabis aux personnes qui en ont besoin. La prohibition ne protège pas les Canadiens contre les dangers du cannabis; la prohibition détruit la vie des Canadiens. »[42]

Puisque ces organismes fonctionnent présentement dans une « zone grise », nous espérons que les autorités policières utiliseront leurs pouvoirs discrétionnaires de façon libérale et feront preuve d'une réserve raisonnable. Certains commentaires de

---

[40] *Ibid.*, para. 47-48.
[41] *Ibid.*, para. 49
[42] Délibérations du Comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, numéro 10, page 41.

Mme Black nous permettent d'être optimistes à cet égard, mais le climat et les pratiques devront changer dans d'autres régions du pays.

Pour créer un système de distribution à des fins thérapeutiques transparent, ces centres de distribution devraient être autorisés sous licence et réglementés de façon appropriée. L'une des conditions de la licence devrait préciser que ces centres ne distribueront que du cannabis à des fins thérapeutiques aux personnes ayant une condition ou les symptômes énumérés. De plus, les centres de distribution devraient garder des dossiers convenables et produire des rapports périodiques. Ces renseignements permettraient à Santé Canada de tenir un registre des membres des centres de compassion et surtout de constituer ainsi une banque de données précieuses pour la recherche scientifique. Les dossiers devraient donc inclure des informations sur la condition médicale du patient et son évolution, les quantités consommées et les effets observés. Les centres devraient aussi s'assurer que des mesures de sécurité sont en place et seraient soumis à des inspections pour s'assurer qu'ils respectent les règlements.

Nous reconnaissons que ces règlements pourront faire augmenter les coûts d'opération des centres de distribution, mais nous pensons qu'ils sont essentiels pour s'assurer qu'il existe des contrôles appropriés de la consommation de cannabis médicinal à des fins thérapeutiques. Nous insistons fortement pour que les coûts induits par la réglementation soient gardés à un minimum, pour que les prix du cannabis n'en réduisent pas l'accessibilité.

Pour ce qui est de l'obtention des produits, les centres devraient accepter d'être approvisionnés par des producteurs accrédités. Ces producteurs pourront cultiver du cannabis uniquement à des fins thérapeutiques – la séparation entre le système à des fins thérapeutiques et celui à des fins récréatives est cruciale. Les producteurs accrédités seraient réglementés de façon appropriée – surtout pour s'assurer que des mesures de sécurité sont en place – et devraient produire des produits sécuritaires et de qualité élevée.

Produits

Présentement, la Réglementation sur l'accès à la marijuana à des fins médicales n'autorise que la possession de marijuana séchée. Aucun autre produit dérivé du cannabis n'est autorisé. Cette position n'est pas justifiée par la recherche et la pratique actuelle et nous recommandons que le programme soit étendu de façon à autoriser d'autres produits dérivés du cannabis.

Coûts

Plusieurs témoins nous ont dit que les personnes consommant du cannabis à des fins thérapeutiques souffrent de maladies débilitantes graves qui ont un impact négatif sur leur situation financière. Nous reconnaissons que l'assurance-médicaments offerte par les régimes d'assurance relève, généralement, des provinces. Néanmoins, nous

pensons que l'achat de marijuana à des fins thérapeutiques et l'achat de l'équipement nécessaire à sa production devraient être considérés, par la *Loi de l'impôt sur le revenu*, comme étant des frais médicaux.

Réglementation sur l'accès à la marijuana à des fins médicales	Propositions du comité
Admissibilité	**Admissibilité**
• Le médecin doit confirmer la condition médicale du patient, les symptômes associés à la condition ou au traitement, que la consommation recommandée de marijuana atténuerait les symptômes et que les bienfaits de la consommation recommandée de marijuana seront plus importants que les risques associés à la consommation.	• Le diagnostic d'un médecin ou d'un autre spécialiste médical accrédité par un collège provincial des médecins et des chirurgiens devrait suffire pour autoriser la consommation à des fins thérapeutiques.
• Le demandeur doit consulter un (catégorie 2) ou deux (catégorie 3) spécialistes pour les symptômes associés à la condition médicale correspondant à la catégorie 2 et à la catégorie 3.	• Éliminer le besoin de consulter un ou deux spécialistes.
• En général, tous les traitements conventionnels ont été essayés ou envisagés.	• Éliminer la condition exigeant que tous les traitements conventionnels ont été essayés ou envisagés avant de pouvoir consommer du cannabis.
• Trois catégories d'admissibilité.	• Éliminer les trois catégories et énumérer les conditions médicales ou les symptômes pour lesquels la consommation de cannabis serait autorisée – mettre régulièrement la liste à jour en se fondant sur les recherches pertinentes.
Accès	**Accès**
• Les patients doivent cultiver leur propre approvisionnement ou désigner une personne qui le cultivera à leur place.	• Les patients pourraient cultiver du cannabis eux-mêmes ou l'obtenir auprès d'un centre de distribution accrédité qui s'approvisionne auprès d'un producteur accrédité.
Produits	**Produits**
• Limités au cannabis (marijuana).	• Comprend tous les produits dérivés du cannabis.
Posologie	**Posologie**
• Établie par le médecin.	• Serait déterminée par le patient, avec l'aide du centre de distribution accrédité.

POURSUIVRE LA RECHERCHE

Le Bureau de l'accès médical au cannabis de Santé Canada administre la Réglementation sur l'accès à la marijuana à des fins médicales. Il coordonne aussi d'autres initiatives relatives au cannabis, dont la recherche sur la sécurité et l'efficacité de la marijuana utilisée à des fins thérapeutiques et l'établissement d'une source canadienne fiable de marijuana propre à la recherche.

Tel que mentionné précédemment, Santé Canada a publié un rapport, en juin 1999, qui annonçait le lancement d'un plan de recherche sur l'utilisation de la marijuana à des fins thérapeutiques.[43] Échelonné sur 5 ans, ce plan devait permettre d'évaluer les risques et les bénéfices de la consommation de marijuana à des fins médicales. Le plan comprenait les éléments suivants :

- Des projets examinant les problèmes de sécurité et d'efficacité associés à la marijuana fumée et aux cannabinoïdes ;
- Des mécanismes d'accès à la marijuana à l'extérieur des projets (par exemple, les exemptions à l'article 56 discutés plus tôt dans le chapitre) ; et
- L'établissement d'une source canadienne de marijuana propre à la recherche.

Recherche scientifique

Dans le cadre de la stratégie du gouvernement sur la consommation de marijuana à des fins médicales, Santé Canada a décidé de commanditer des études pour évaluer la sécurité et l'efficacité de la marijuana fumée et des cannabinoïdes. Selon le ministère, les connaissances sur la valeur thérapeutique de la marijuana fumée sont largement anecdotiques et les données provenant d'études scientifiques sur la sécurité et l'efficacité de la marijuana à des fins thérapeutiques sont contradictoires. Le ministère était aussi préoccupé par les risques pour la santé associés à la consommation de marijuana, surtout lorsqu'elle est fumée.

La stratégie a été élaborée sur l'avis du Comité consultatif d'experts sur les nouvelles substances actives du Programme des produits thérapeutiques. Ce comité est un organisme externe composé d'experts scientifiques et médicaux qui a pour mandat de conseiller le Programme des produits thérapeutiques.

En partenariat avec les Instituts de recherche en santé du Canada, un organisme subventionnaire qui assure aussi la validité scientifique des études, Santé Canada s'est engagé à financer le Programme de recherche sur l'usage de la marijuana à des fins médicinales à hauteur de 7,5 millions $ au cours des cinq prochaines années. Il se concentre principalement sur la forme de marijuana fumée, même si des initiatives futures se concentreront sur la marijuana non fumée et les cannabinoïdes.

---

[43] Santé Canada, Programme des produits thérapeutiques, *Plan de recherche sur la marijuana à des fins médicales : Un rapport d'étape*, 9 juin 1999.

Au moins deux études ont été planifiées :

- En juillet 2001, Santé Canada et les Instituts de recherche en santé ont annoncé une contribution de 235 000 $ pour une étude pilote à l'Université McGill sur 32 patients afin d'évaluer les effets de la marijuana fumée sur la douleur neuropathique chronique.
- En juin 2001, Santé Canada a accordé un financement de 840 000 $ à la *Community Research Initiative of Toronto* (CRIT) pour un projet de recherche sur l'efficacité de la marijuana fumée pour le traitement de la cachexie chez les personnes atteintes du VIH/SIDA. Ce projet entamait alors la deuxième des trois phases prévues sur la marijuana fumée, portant sur les effets aigus du cannabis fumé sur l'appétit des personnes atteintes du VIH/SIDA. Il s'agit d'une étude pilote sur échantillon aléatoire, à double insu, contrôlée avec placebo et croisée.

Toutefois, aucun de ces projets n'est présentement en cours, car les chercheurs n'ont pas accès à de la marijuana.

En plus de ces projets pilotes, Santé Canada a annoncé que de la marijuana de qualité « recherche » serait fournie aux personnes admissibles qui accepteraient de fournir des renseignements médicaux à des fins de surveillance et de recherche. Ici encore, Santé Canada n'a toujours pas fourni la marijuana aux consommateurs autorisés.

Santé Canada a indiqué que les connaissances acquises grâce au programme de recherche général seraient utilisées, en partie, pour modifier au besoin, la Réglementation sur l'accès à la marijuana à des fins médicales. Par exemple, la liste des symptômes énumérés dans la catégorie 2 pourrait être révisée ou la posologie quotidienne précisée. Santé Canada a aussi indiqué que si les études ne révélaient aucun bénéfice à l'usage de la marijuana, il remettrait en question l'utilité de la Réglementation.

Il est évident que des recherches sur les effets thérapeutiques de la marijuana sont essentielles. Alors qu'on peut féliciter Santé Canada d'avoir adopter un plan de recherche, nous ne pouvons que déplorer les délais encourus dans leur démarrage. Les projets pilotes autorisés n'ont pas encore commencé parce que le Canada doit obtenir la marijuana propre aux études d'une source américaine. Cela signifie que des organismes américains, le *National Institute on Drug Abuse* dans ce cas-ci, ont le droit de revoir les protocoles de recherche canadiens pour déterminer s'ils fourniront de la marijuana aux chercheurs canadiens.

> *« Le NIDA, le National Institute on Drug Abuse des États-Unis, était notre première source de marijuana à des fins de recherche. C'était plutôt le premier organisme avec lequel nous avons communiqué. Ils ont des graines et des produits séchés. Nous négocions toujours avec eux pour obtenir des produits séchés.*

Afin de pouvoir utiliser leurs produits, le ministère de la santé américain et le NIDA doivent approuver les protocoles qui utilisent le produit en question. Après que les organismes aient autorisé les protocoles scientifiques, il faut consulter la DEA pour savoir si elle permettra l'exportation. »[44]

De toutes manières, le fait que des études additionnelles soient nécessaires ne signifie pas que la consommation à des fins thérapeutiques se soit pas justifiée dans certaines circonstances. Les études en cours – ici et dans d'autres pays comme le démontrera le chapitre 20 – devraient permettre de vérifier les informations existantes et d'identifier d'autres conditions médicales ou symptômes sur lesquels le cannabis aurait un effet thérapeutique. Enfin, autant la recherche sur la valeur médicinale du cannabis est une priorité, autant il est nécessaire de mener des études sur des modes d'administration de rechange aussi efficaces que le fait de fumer le cannabis.

Avant de conclure sur cette question, il nous faut souligner regretter que l'immense réservoir de connaissances et d'expertise des clubs de compassion ne fasse pas partie des sources de données du plan de recherche de Santé Canada. Ces organismes oeuvrent à la marge du système, nous le savons. Cela n'empêche pas que les informations dont ils disposent mériteraient d'être recueillies et analysées à des fins de recherche.

Nous remettons aussi en question la validité d'études qui n'utilisent que du cannabis de qualité inférieure et de faible puissance, qu'il soit fourni par le *National Institute on Drug Abuse* ou provienne du Canada. Nous avions vu au chapitre 9 que la marijuana fournie par le NIDA est, de l'avis de certains chercheurs, de qualité douteuse pour des études sur les applications thérapeutiques. Hilary Black, fondatrice et codirectrice de la B.C. Compassion Club Society, a renchéri :

« Nous avons créé, en association avec une équipe de chercheurs scientifiques de Vancouver, un plan de recherche. Par contre, nous avons essuyé un refus, car nous ne voulions pas effectuer une étude utilisant un placebo ou du cannabis de qualité inférieure et de faible puissance fourni par le US National Institute on Drug Abuse. Toute étude essayant de prouver l'efficacité du cannabis à des fins médicales qui utilise une herbe de si faible puissance ou de souche inconnue, tel que le cannabis cultivé au Canada par Plant Prairie Systems, sera un échec. Il n'y a pas lieu d'importer du cannabis à des fins de recherche, lorsqu'on tient compte de la qualité élevée de la marijuana et de l'énorme quantité produite au Canada. Les médecins, les patients, les compagnies pharmaceutiques, Plant Prairie Systems et Santé Canada demandent le même type de renseignements que nous pourrions recueillir. Malheureusement, nous n'avons pas les ressources financières pour effectuer cette recherche. »[45]

---

[44] Gillian Lynch, directrice générale, Programme de la stratégie antidrogue et des substances contrôlées, Santé Canada, Délibérations du Comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001-2002, numéro 22, pages 47-48.

[45] Délibérations du Comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001, fascicule 10, pages 38-39.

Marijuana propre à la recherche

Santé Canada voulait d'ailleurs créer une source canadienne de marijuana propre à la recherche. Le 5 mai 2000, Travaux publics et Services gouvernementaux Canada a émis un appel de soumissions pour identifier une source canadienne de marijuana de qualité, abordable, normalisée propre à la recherche scientifique. Au départ, la marijuana devait être fournie uniquement aux scientifiques qualifiés et autorisés à des fins de recherche. Les critères d'évaluation des propositions reçues comprenaient la situation financière du soumissionnaire, la compétence de son personnel, les normes de sécurité, etc. Aucune expérience en culture de marijuana n'était exigée, même si on demandait de l'expérience en matière de culture de végétaux destinés à la consommation humaine.

En décembre 2000, un contrat a été accordé à *Prairie Plant Systems Inc.* (PPS) de Saskatoon. Cette entreprise devait fournir à Santé Canada une source fiable de marijuana abordable, de qualité et normalisée à des fins médicales et de recherche. Santé Canada a annoncé que, d'ici l'établissement d'une source d'approvisionnement nationale, elle demanderait au *U.S. National Institute of Drug Abuse* de lui fournir de la marijuana propre à la recherche pour les essais cliniques effectués par des chercheurs au Canada.

PPS s'est conformé aux exigences du contrat quant à la sécurité. L'entreprise a reçu l'autorisation de cultiver de la marijuana propre à la recherche dans une mine abandonnée de Flin Flon, au Manitoba. Même si cette décision semble en amuser plusieurs, Santé Canada la justifie en invoquant le niveau de sécurité du site et la possibilité de contrôler la température, le niveau d'humidité et les conditions de culture.

Le premier lot devait être fourni à Santé Canada au début de 2002. Selon les modalités du contrat de 5 ans de 5,7 millions $ l'entreprise devait :

- Établir et faire fonctionner un établissement de culture, de traitement, de fabrication et de stockage de marijuana ;
- Effectuer des tests en laboratoire et le contrôle de la qualité de la marijuana, tout au long du cycle de vie du produit ;
- Fabriquer, emballer, étiqueter et stocker la marijuana ;
- Distribuer la marijuana aux personnes autorisées par Santé Canada ; et
- Se conformer aux conditions de la *Loi réglementant certaines drogues et autres substances*, y compris les mesures de sécurité et physiques sévères.

Ce printemps, Santé Canada a révélé que la première culture ne pourrait pas être utilisée à des fins de recherche en raison de sa qualité variable. Alors que le ministère espérait obtenir des graines du *National Institute on Drug Abuse*, les graines utilisées provenaient de saisies effectuées par les autorités policières au Canada, de sorte que la marijuana obtenue était de souches et de caractéristiques différentes. Santé Canada a mentionné l'importance de la marijuana propre à la recherche :

> *« Si nous rappelons nos commentaires précédents sur les raisons expliquant pourquoi Santé Canada est impliqué dans l'étude sur la marijuana à des fins médicales, il s'agit d'obtenir les preuves scientifiques nécessaires pour savoir quels sont les bénéfices de la marijuana. Pour obtenir ces preuves scientifiques, il faut avoir un produit de base qui respecte les normes de recherche. La question n'est pas de savoir si Prairie Plant Systems a bel et bien cultivé de la marijuana; il faut savoir si l'entreprise a cultivé un produit qui respecte les normes de la recherche et qui peut être utilisé lors de recherches scientifiques légitimes. »*[46]

Nous comprenons cet argument. Nous ne voyons cependant pas ce qui justifierait qu'on ne peut pas distribuer ce cannabis aux personnes autorisées à la consommer conformément à la *Loi réglementant certaines drogues et autres substances*, surtout lorsque la sécurité du produit, en termes de pesticides, de moisissures, etc., n'est pas en cause.

CONCLUSIONS

Soulignons que les modifications que nous proposons à la Réglementation sur l'accès à la marijuana à des fins médicales doivent garantir que l'utilisation à des fins thérapeutiques est limitée aux cas où il y a un réel besoin médical, et que la distribution et la production sont effectuées à l'aide d'une licence octroyée par le gouvernement.

Conclusions du chapitre 13

- **La Réglementation sur l'accès à la marijuana à des fins médicales ne constitue pas le cadre humanitaire qu'elle se proposait d'être et restreint inutilement la disponibilité de la marijuana pour les patients qui pourraient en bénéficier.**
- **Le fait que la communauté médicale refuse de jouer le rôle de « gardien » du cannabis thérapeutique et qu'il est impossible d'avoir accès à des sources légales de cannabis semble rendre le présent cadre réglementaire d'exemption « illusoire », soulevant ainsi à nouveau des questions quant aux dispositions de la Charte.**
- **La réglementation n'a visiblement pas atteint son objectif d'être plus accessible : en près d'un an, 498 demandes ont été reçues (contre plus de 550 en vertu de l'ancienne exemption) et seulement 255 personnes ont reçu l'autorisation de posséder de la marijuana à des fins thérapeutiques.**

[46] Dann Nichols, sous-ministre adjoint, Direction générale de la Santé environnementale et sécurité des consommateurs, Santé Canada, Délibérations du Comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001-2002, fascicule 22, page 46.

	➢ **Il est urgent de modifier les règles d'admissibilité et l'accessibilité au cannabis aux fins thérapeutiques.** ➢ **Les études sur la sécurité et l'efficacité du cannabis n'ont pas commencé car les chercheurs ne peuvent pas obtenir le produit nécessaire pour qu'ils effectuent les études. Cette situation regrettable en soi ne doit pas de surcroît pénaliser davantage les personnes qui ont besoin de cannabis aux fins thérapeutiques.** ➢ **Il est regrettable que le plan de recherche de Santé Canada n'ait pas prévu d'utiliser l'immense bassin de connaissance que détiennent les clubs de compassion.** ➢ **L'élaboration d'une source canadienne de marijuana propre à la recherche a été un échec.**

CHAPITRE 14

PRATIQUES POLICIÈRES

Les opinions sur la mise en application des lois sur les drogues illicites par la police sont à tout le moins inconsistantes sinon tout à fait contradictoires. Certains croient que la police consacre trop de temps, d'efforts et de ressources aux enquêtes sur les infractions relatives aux drogues illicites, spécifiquement lorsqu'il s'agit de possession simple et plus encore quand elles impliquent du cannabis. D'autres – dont la police elle-même – prétendent que les priorités sont déjà axées sur les trafiquants et les producteurs et que les accusations de possession, surtout s'il s'agit de cannabis, sont le plus souvent incidents à la détection d'autres activités criminelles.

Ce chapitre décrit d'abord les principales organisations responsables de mettre en application les dispositions de la *Loi réglementant certaines drogues et autres substances* (LRDS). La section suivante examine les pouvoirs qui leur sont impartis ainsi que les techniques utilisées lors des enquêtes sur les drogues illicites. Enfin, la troisième section se penche sur les principales statistiques se rapportant à la police. Ces renseignements devraient permettre de faire la lumière sur certaines des idées fausses entourant la mise en application des lois sur les drogues illicites.

ORGANISMES D'EXÉCUTION DE LA LOI

Plusieurs organismes participent à la mise en application des lois canadiennes sur les drogues illicites, principalement la GRC, l'Agence des douanes et du revenu du Canada (ADRC), ainsi que les forces policières provinciales et municipales. Ces intervenants collaborent au besoin avec de nombreux autres organismes comme la Défense nationale, Pêches et océans et la Garde-côtière canadienne

GRC

Le rôle et le mandat de la GRC consistent à faire respecter les lois, prévenir le crime et maintenir la paix, l'ordre et la sécurité. Dans le cadre de la stratégie canadienne sur les drogues, la GRC participe principalement à quatre aspects, soit la mise en

application et le contrôle, la coordination nationale, la coopération internationale, et les programmes de prévention.

Sur le plan national, les responsabilités de la GRC en matière de lutte antidrogues sont confiées principalement à deux groupes :

- La Division de la lutte antidrogues. Comptant environ 900 employés, ce service est responsable de la lutte antidrogues au Canada depuis son siège social à Ottawa et ses divisions de lutte antidrogues dans les diverses régions du pays. Ce service constitue également une voie de communication rapide avec les membres de la communauté internationale de la lutte antidrogues.
- L'Initiative intégrée de contrôle des produits de la criminalité. Avec environ 415 employés, ce groupe est chargé d'enquêter sur les personnes ayant accumulé certains produits de la criminalité et de saisir les actifs provenant d'activités criminelles. Puisqu'on estime que 90 % des saisies effectuées touchent les drogues, on considère qu'il s'agit principalement d'une initiative antidrogues. Les 13 unités comptent à leur service des membres des forces policières fédérales, provinciales et municipales, des conseillers juridiques, des agents des douanes, des enquêteurs de l'impôt, des gestionnaires d'actifs et des juricomptables. Les cas dans ce domaine ont tendance à être complexes et interminables.

Ces deux services reçoivent également l'aide des autres divisions de la GRC comme les renseignements et d'autres services d'enquête spécialisés dont la surveillance électronique et physique. Les priorités actuelles consistent à enquêter et à arrêter les têtes dirigeantes des organisations criminelles s'adonnant au commerce des drogues et à saisir les produits de la criminalité. La GRC a adopté une approche basée sur les renseignements et effectue ses enquêtes en fonction de cibles spécifiques – par exemple le crime organisé. Analysant l'information qui lui provient de son service de renseignements pour identifier les principales menaces au pays, elle établit ainsi des priorités nationales de façon à concentrer ses ressources sur les domaines qui posent le plus de risque pour les Canadiens. On réévalue, modifie et redéfinit les priorités nationales en fonction des renseignements recueillis. Ces priorités – par exemple, celle qui concerne les bandes de motards hors-la-loi – permettent de s'attaquer plus précisément à certains groupes. Complexes et pouvant prendre plusieurs années avant d'aboutir, ces enquêtes demandent des ressources considérables.

Lorsque la GRC a comparu devant le Comité au mois d'octobre 2001, elle a présenté les priorités nationales suivantes :

> *« À l'heure actuelle, nos priorités stratégiques nationales concernent les bandes de motards hors-la-loi, le crime organisé asiatique, le crime organisé italien et le crime organisé d'Europe de l'Est. Il s'agit là d'objectifs nationaux et non d'objectifs en rapport avec les drogues. Ce sont là les objectifs nationaux de*

la GRC. Ces groupes sont impliqués dans tous les domaines, mais vous remarquerez qu'ils prennent part tous les quatre aux activités relatives aux drogues illicites. » [1]

La GRC collabore étroitement avec d'autres agences nationales et internationales pour combattre l'entrée des drogues au Canada. À ce titre, elle participe régulièrement à des opérations policières conjointes – menées par des groupes de travail permanents ou temporaires selon le cas – pour enquêter sur les activités criminelles et échanger des renseignements. Elle entretient ainsi des relations étroites avec les services de police provinciaux et municipaux, Interpol, les Nations Unies, l'Organisation des États Américains, la Défense nationale, Pêches et océans, le Service correctionnel canadien, la Garde-côtière du Canada, ainsi qu'avec les autorités douanières et les agences de lutte antidrogues de par le monde comme la *Drug Enforcement Administration* (DEA), le FBI et les douanes américaines.

Active aussi dans le domaine de la prévention, la GRC a mis sur pied le Service de sensibilisation aux drogues. Disposant d'un budget de 4 millions $ et comptant 31 employés, ce service agit au niveau local, offrant des cours aux élèves, parents, athlètes, entraîneurs, employés, employeurs et groupes communautaires. L'ensemble du personnel de la GRC – et non seulement ces 31 employés à temps plein en prévention – offre ainsi plus de 10 000 présentations par année. Parmi les programmes offerts, mentionnons le *Drug Abuse Resistance Education* (DARE)[2], le *Programme «Notre bouclier» pour les jeunes autochtones*, le programme *Dans les deux sens : les parents, les enfants et les drogues*, ainsi que le programme *La drogue et le sport*.

Dans le cadre des responsabilités policières provinciales et municipales qu'elle assume de façon contractuelle, la GRC joue aussi un rôle au plan local dans la lutte antidrogues. Le sergent MacEachern, coordonnateur de la lutte antidrogues au Nouveau-Brunswick, nous explique :

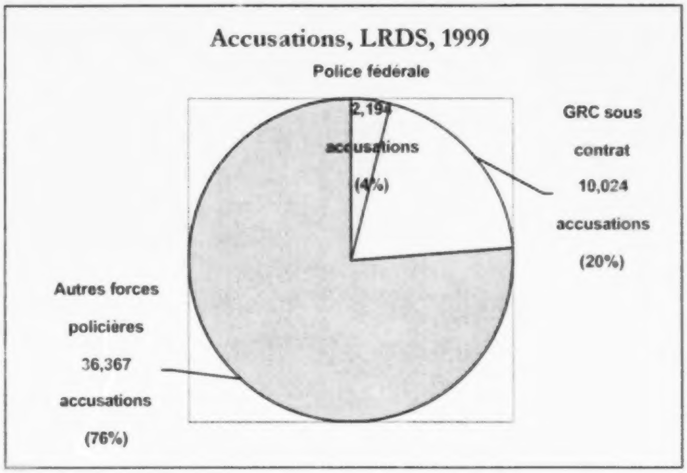
> *« La GRC est liée par un contrat avec la province du Nouveau-Brunswick et, en tant que tel, nous offrons des services policiers dans toutes les régions rurales de la province, dans plusieurs des petits districts et des petites municipalités, ainsi que dans un grand nombre de municipalités plus vastes. De plus, nous disposons d'unités fédérales chargées de l'application de la loi ici et là dans la province, et en matière de lutte antidrogues, nous avons des bureaux à Bathurst, Moncton, Saint-Léonard, Saint John et Fredericton.*
>
> *Autrement dit, notre personnel d'application de la loi réalise des enquêtes à grande échelle impliquant les groupes criminels organisés sur les plans provincial, interprovincial, national et international. Nos détachements provinciaux ou contractuels doivent s'occuper des trafiquants de drogue à l'échelle locale ou dans les rues, mais il arrive souvent, dans le but de contrer un trafic intense sur le plan local, que nos unités fédérales s'associent à nos détachements afin de réaliser un objectif précis. »* [3]

---

[1] R..G. Lesser, surintendant principal, GRC, Délibérations du Comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001, numéro 8, page 11.

[2] Nous discutons plus en profondeur du cas du programme DARE au chapitre 17.

[3] Présentation au Comité le 5 juin 2002.



Même si nous abordons plus loin les statistiques relatives à la lutte antidrogues, il est intéressant d'observer que selon Rapport de 2001 de la vérificatrice générale,[4] la GRC était responsable d'environ 24 % de toutes les accusations portées en vertu de la *Loi réglementant certaines drogues et autres substances* en 1999. Comme le démontre le graphique ci-contre, seulement 4 % de ces accusations étaient attribuables à ses services de police fédérale (soit 2194 sur un total de 49 585). Dans ce graphique, le « nombre de personnes accusées » est réparti selon la gravité des infractions pour un incident donné et il fait référence au nombre de personnes accusées par la police ou contre lesquelles la police a recommandé qu'on porte des accusations.

L'Agence des douanes et du revenu du Canada[5]

L'ADRC – qui compte présentement plus de 8 000 employés – a toujours joué un rôle de premier plan dans la lutte antidrogues au Canada et elle est chargée d'intercepter les drogues au point d'entrée. Il s'agit là d'une tâche importante, puisque plusieurs des drogues illicites qu'on retrouve au Canada sont introduites en fraude à nos frontières – même si cela est moins vrai pour le cannabis dont une partie significative est cultivée au pays.

La *Loi sur les douanes* confère certains pouvoirs aux agents des douanes. En vertu de l'article 98 un agent peut fouiller toute personne arrivée au Canada s'il la soupçonne, pour des motifs raisonnables, de dissimuler sur elle ou près d'elle tout objet d'infraction, effective ou éventuelle, à la présente loi, tout objet permettant d'établir une pareille infraction ou toute marchandise d'importation ou d'exportation prohibée, contrôlée ou

[4] *Rapport de la vérificatrice générale du Canada à la Chambre des communes*, 2001, chapitre 11, « Les drogues illicites : le rôle du gouvernement fédéral, » page 11.

[5] Cette section repose dans une grande mesure sur le témoignage de Mark Connolly, directeur général, Direction du renseignement et de la répression de la contrebande, Direction générale des douanes, Agence des douanes et du revenu du Canada, Délibérations du Comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001, numéro 8, pages 33-39.

réglementée en vertu de la présente loi ou de toute autre loi fédérale. De plus, selon l'article 99, l'agent peut « visiter toute marchandise importée ».

L'ADRC fait face à divers types de contrebande dont les armes à feu, l'alcool, le tabac et les drogues. Tout comme la GRC, elle fonctionne sur la base de renseignements qui lui proviennent de son vaste réseau et d'autres organismes d'exécution (au pays et à l'étranger). Ainsi, son programme de renseignements sur la contrebande travaille étroitement avec les organismes d'exécution canadiens et étrangers afin d'accumuler des renseignements, des indicateurs et des tendances lui permettant d'identifier les cargaisons et/ou individus suspects avant qu'ils n'arrivent à la frontière.

Les programmes d'exécution reposent sur la planification stratégique, la gestion des risques, la collecte et la diffusion des renseignements, les partenariats et la formation efficace du personnel. La Direction du renseignement et de la répression de la contrebande – dont la priorité consiste à s'attaquer aux drogues illicites – est chargée de la conception, l'élaboration et la mise en application des stratégies relatives à la contrebande et aux programmes de renseignements. En raison d'un volume croissant, l'ADRC a élaboré le *Plan d'action des douanes* afin de moderniser ses processus douaniers et d'analyse des risques.

Le service du renseignement et de la répression de la contrebande de l'ADRC est composé d'agents du renseignement et d'analystes. Ses diverses unités sont chargées de recueillir des renseignements et de maintenir des bases de données qui seront diffusés aux agents de première ligne au pays afin de les aider à identifier les personnes et les marchandises à risque qui se présentent aux frontières.

En plus de partenariats avec d'autres organismes d'exécution de la loi au Canada, comme la GRC et les polices provinciales et municipales, l'ADRC est en relation étroite avec d'autres administrations douanières, des organismes nationaux et internationaux d'exécution de la loi et des intervenants externes dans les domaines de la contrebande, les renseignements, l'exportation stratégique et le contre-terrorisme tels le *United States Customs Service*, la *Drug Enforcement Administration*, l'Organisation mondiale des douanes, la Conférence douanière inter-Caraïbes et l'Interpol. L'ADRC participe régulièrement à des opérations conjointes de courte et de longue durée. Par exemple, les équipes intégrées de la police des frontières (EIPF) sont le fruit d'une initiative canado-américaine entre plusieurs agences d'exécution de la loi qui vise à contrer le crime frontalier. De plus, l'ADRC et la police joignent régulièrement leurs ressources à celles des organismes d'exécution locaux, provinciaux et américains afin de combiner leur expertise et leurs renseignements. L'ADRC participe également à l'Initiative intégrée de contrôle des produits de la criminalité décrite précédemment.

Parmi les activités spécifiques à la lutte antidrogues, mentionnons :

- Recours à un équipement de détection de contrebande hautement sophistiqué afin de procéder à des examens non intrusifs visant à faciliter l'identification des stupéfiants – systèmes à rayons X pour examiner les bagages, les camions et les chargements mobiles ; appareils à balayage ionique afin de détecter les quantités infimes de stupéfiants sur presque tout genre de surface ; équipes de chiens pisteurs déployés un peu partout au pays ; trousses de détection de contrebande comprenant certains outils utiles comme des sondes et des fibroscopes ; ainsi qu'un véhicule submersible télécommandé visant à détecter les stupéfiants et autres articles de contrebande fixés sous l'eau à la coque des navires.
- Priorité accordée à la formation des inspecteurs des douanes dans le domaine de l'exécution des lois relatives à la contrebande.
- Utilisation de divers systèmes d'exécution et bases de données, internes et externes, afin de permettre aux douaniers et aux inspecteurs d'identifier le niveau de risque des voyageurs, des transporteurs et/ou des conducteurs.
- Déploiement d'un personnel chargé exclusivement de faire respecter les lois afin de recueillir des renseignements et faire respecter les interdictions en régions. Les agents régionaux du renseignement collaborent avec les autorités policières locales, les agents de ciblage, les enquêteurs et les douaniers pour identifier les mouvements à risque élevé à la frontière. Les équipes d'intervention mobile se composent de douaniers spécialement formés et postés partout au Canada pour mener des activités de surveillance et de vérification, ainsi que des opérations de contrôle auprès de voyageurs choisis de façon aléatoire. Les analystes régionaux du renseignement analysent les saisies importantes afin d'établir des liens avec le crime organisé, et procèdent à des évaluations des tendances pour tenter d'identifier les risques à venir.

L'ADRC estime qu'elle est responsable d'environ 50 % de toutes les saisies de drogues effectuées au Canada.

Polices municipales et provinciales

À travers leurs activités normales de police et des escouades spécialisées, les forces policières provinciales et municipales sont en première ligne en matière de drogues illicites. Elles font la plupart des enquêtes et gèrent la plus grande partie des cas de drogues au Canada. De plus, les membres de ces corps participent fréquemment à des opérations conjointes avec la GRC et/ou l'ADRC, ainsi que d'autres organismes d'exécution. Par exemple, on a informé le Comité d'opérations conjointes présentement menées avec la GRC – et dans certains cas, avec d'autres organismes d'exécution – ainsi qu'avec la police de Toronto, la police de Vancouver et la police de Regina.

COÛTS[6]

À diverses occasions, le Comité a demandé aux forces policières de lui fournir des informations détaillées sur la proportion du temps que les agents consacrent aux affaires de drogue, le nombre d'agents affectés à la lutte antidrogues, etc. Dans la plupart des cas, nous n'avons obtenu aucune réponse à ces questions sauf des énoncés généraux. Ou bien les forces policières étaient réticentes à nous fournir ces renseignements, ou encore leur travail ne se prête pas à ce genre de calculs et personne ne connaît les sommes consacrées à la lutte antidrogues. Dans un cas ou l'autre, ce manque de données nous complique la tâche lorsque vient le temps d'estimer les budgets que la police consacre aux questions relatives aux drogues et de déterminer si on utilise les fonds publics à bon escient.

Il est effectivement difficile d'estimer les coûts de la lutte antidrogues. Quels sont les éléments de coûts à prendre en compte ? Quels sont ceux que l'on devrait laisser de côté en raison d'un manque de données ? Comment définit-on le coût des éléments ? Comment devrait-on mesurer chaque élément de coût ? Peut-on vraiment éviter ces coûts ? Enfin, comment ces divers facteurs influencent-ils la qualité des résultats ?

Le Centre canadien de lutte contre l'alcoolisme et les toxicomanies (CCLAT) a réalisé la dernière étude d'importance des coûts de la toxicomanie au Canada.[7] Cette étude, publiée en 1996, porte sur les données de 1992. Les auteurs estimaient les coûts de la lutte antidrogues comme suit :

Police	**208,3 M $**
Tribunaux	59,2 M $
Services correctionnels (incluant la probation)	123,8 M $
Douanes et accise	**9,0 M $**
Coût total de la lutte antidrogues	400,3 M $

Les coûts policiers correspondent aux coûts des organismes d'exécution de la loi spécialisés, comme la Division des stupéfiants (d'alors) de la GRC, ainsi qu'à la proportion du coût général des opérations policières qu'on peut attribuer aux crimes reliés aux drogues illicites, incluant les violations directes des lois antidrogues et la proportion des crimes généraux qu'on peut attribuer de façon raisonnable aux drogues illicites.

Certaines données sur la proportion des cas d'homicides et d'agressions où l'auteur était sous l'influence de drogues illicites étant connues, l'étude du CCLAT a

---

[6] Cette section repose dans une certaine mesure sur le document intitulé *The Costs of Drug Abuse and Drug Policy*, préparé pour le Comité spécial du Sénat sur les drogues illicites par Antony G. Jackson, Division de l'économie, Direction de la recherche parlementaire, Bibliothèque du Parlement, 22 avril 2002. Nous y revenons aussi au chapitre 21.

[7] Single, E., et coll., (1996) *The Costs of Substance Abuse in Canada: A Cost Estimation Study*, Ottawa : Centre canadien de lutte contre l'alcoolisme et les toxicomanies.

estimé la proportion de ces cas où l'on pouvait attribuer cette infraction à une intoxication de l'auteur. Les auteurs ont proposé que 8 % des crimes violents commis au Canada étaient attribuables aux drogues illicites. Il est à noter qu'il n'a pas été tenu compte des crimes contre la propriété.

Le nombre d'infractions était utilisé pour mesurer le travail policier. Pour estimer le coût total du travail de police en matière de drogues, on a multiplié les dépenses totales des services de police fournies par Statistiques Canada par le pourcentage des infractions qu'on estimait avoir un rapport avec la drogue. Selon l'étude, 2,4 % de toutes les infractions étaient attribuables à la consommation de drogues illicites.

Coûts des services de police pour la mise en application des lois antidrogues du fédéral	168,4 M $
Coûts des services de police pour 8 % des crimes violents	39,9 M $
Coût total des services de police	208,3 M $

Les données sur les Douanes et accises ne tiennent pas compte des programmes financés par la Stratégie antidrogue.

Bien que nous ne soyons pas en mesure d'étudier en profondeur les coûts de la lutte contre les drogues illicites par la GRC, l'ADRC, ainsi que les polices provinciales et municipales, nous pouvons affirmer sans aucun doute que les coûts actuels de la lutte antidrogues excèdent considérablement l'estimation de 210 millions $ produite en 1992.

En effet, le Rapport de 2001 de la vérificatrice générale estimait que la GRC avait consacré à elle seule environ 164 millions $ à la lutte contre les drogues illicites en 1999.[8] Cette estimation reposait sur les données détaillées relatives aux dépenses recueillies dans le cadre du programme fédéral de la lutte antidrogues. Ce montant comprenait les coûts découlant directement de l'exécution des lois antidrogues, ainsi que les coûts dans les domaines connexes comme les initiatives touchant les fruits de la criminalité, et les douanes et accises.

Ce montant de 164 millions $ ne concerne que les services de police fédéraux de la GRC et **n'inclut pas** les services de police rendus par la GRC en vertu des contrats avec les provinces et les municipalités qui constituent cependant l'essentiel des dépenses de la GRC. On nous a déclaré qu'il était à l'heure actuelle impossible de déterminer avec précision les coûts en rapport avec la lutte aux drogues illicites pour ces services.

> *« Dans le cas des services de police à contrat, on mène la lutte antidrogues conjointement avec d'autres services, par exemple, alors que les agents exécutent des tâches uniformes, soit les tâches policières générales dans les communautés. Par conséquent, il est difficile de déterminer la partie du temps consacré aux diverses activités. Cette difficulté s'accroît lorsque l'infraction en matière de drogue résulte d'un autre crime, ce qui est souvent le cas.*

---

[8] Rapport de la vérificatrice générale du Canada à la Chambre des communes, 2001, chapitre 11, « Les drogues illicites : le rôle du gouvernement fédéral, » page 17.

On doit tenir compte du fait que le coût des services policiers consiste en grande partie du salaire et des avantages consentis aux membres. Pour déterminer avec précision le coût de la lutte antidrogues en matière de services de police à contrat, il nous faut mesurer le temps consacré à cet effort.

Alors qu'on le fait pour les membres de la GRC au niveau fédéral, le système présentement utilisé pour les services de police à contrat ne permet pas de recueillir cette information. On s'efforce présentement d'élaborer un nouveau système qui permettrait possiblement d'accumuler ces renseignements. Cependant, en raison de l'éventail des tâches policières effectuées jour après jour, il est évident que ce serait tout un défi que de faire la distinction nette des activités relatives à la drogue.

...Permettez-moi maintenant d'aborder les coûts assumés par les forces policières provinciales et municipales. Nous avons récemment mis sur pied un processus visant à identifier les renseignements existant sur le plan des coûts d'exécution et les lacunes à ce niveau. Le mois dernier, lors de la plus récente réunion du Comité national de coordination sur le crime organisé dont je suis le président, notre ministère a distribué un questionnaire visant à recueillir des renseignements sur les coûts d'exécution dans les provinces et les territoires. On a depuis ce temps remis le questionnaire à plusieurs corps policiers au pays par l'intermédiaire de l'Association canadienne des commissions de police. Nous attendons impatiemment d'en analyser les résultats dès que nous les aurons reçus. »[9]

Ces résultats nous intéressent aussi puisqu'ils constitueraient l'information la plus précise à ce jour. Comme nous l'avons expliqué précédemment, il nous est apparu extrêmement difficile, voire impossible, de connaître la ventilation des coûts des activités de lutte antidrogues pour les corps de police provinciaux et municipaux. Même si le chef Fantino du service de police de Toronto a indiqué que « probablement le tiers de nos ressources sont englouties dans un aspect ou l'autre de la lutte antidrogues, »[10] ce type de déclaration ne nous permet pas de tirer des conclusions concrètes quant aux coûts du maintien de l'ordre. Cependant, on nous a dit que les enquêtes sur la drogue – en particulier celles qui visent à coincer les réseaux de trafiquants – peuvent exiger des ressources intensives.

« Les ressources ainsi utilisées sont considérables en raison de la nature du travail. Celui-ci est complexe et, comme vous le précisez, il implique la surveillance et même parfois l'écoute électronique. On doit faire appel à un réseau de gens qui travaillent de façon clandestine. La police requiert un temps énorme afin de réunir une preuve crédible pour mettre le réseau à jour, établir des liens et procéder ensuite à des corrélations de tous ces éléments devant la cour. Il s'agit là d'un aspect du travail des policiers qui demande bien des ressources et qui, par conséquent, est très onéreux pour le service de police. » [11]

---

[9] Paul E. Kennedy, Sous-ministre adjoint principal au solliciteur général, Secteur de la police et la sécurité, ministère du Solliciteur général, Délibérations du Comité spécial sur les drogues illicites, Sénat canadien, première session de la trente-septième législature, 2001-02, numéro 22, pages 9-10.

[10] Le chef Julian Fantino, service de police de Toronto, Délibérations du Comité spécial sur les drogues illicites, Sénat canadien, première session de la trente-septième législature, 2001, numéro 5, page 11.

[11] Le chef Cal Johnston, service de police de Regina, Délibérations du Comité spécial sur les drogues illicites, Sénat canadien, première session de la trente-septième législature, 2001-02, numéro 16, page 31.

Il n'est toutefois pas certain que ce raisonnement sur les coûts s'applique également aux cas de possession de cannabis.

> *« La consommation de cannabis, sauf lorsqu'elle coïncide avec une rencontre avec un agent de police, ne justifie pas une enquête policière, du moins pas dans cette communauté. Nous ne nous amusons pas à piéger les gens qui ne font que consommer le cannabis. Nous les trouvons cependant en nous adonnant à nos activités dans de nombreuses autres circonstances. Nous les trouvons dans le cadre des enquêtes relatives au trafic de stupéfiants, puisque nous sommes alors confrontés à des consommateurs et c'est alors qu'on porte des accusations. Nous les trouvons lors des chicanes de ménage. Nous les trouvons lors des enquêtes touchant les débits de boisson et parfois lors d'infractions au code de la route. Leur présence est une conséquence de l'enquête.*
>
> *Pour ce qui est de s'attaquer au trafic et à la culture du cannabis, il s'agit là du principal but de nos enquêtes sur la drogue. L'argent provenant de la culture et du trafic du cannabis se retrouve dans les autres types de crimes. Dans certaines communautés, il s'agit d'un crime plus officiel et mieux organisé, alors que dans d'autres, il s'agit de groupes de criminels affiliés qui ne s'y adonnent que pour les profits. C'est d'ailleurs à ce niveau que nous exerçons nos activités. »*[12]

En ce qui concerne le coût des douanes, l'ADRC a précisé que 75 millions $ sur un budget de l'ordre de 410 millions $ en 2001-2002 ont été consacrés à l'interdiction des drogues illicites dans des domaines comme les équipes d'intervention mobiles, les unités régionales, le programme d'examen des conteneurs, le centre d'expertise marine, les analystes de renseignements et les agents régionaux du renseignement. Ces coûts découlent aussi de la technologie de détection de la contrebande qui comprend les systèmes à rayons X, les spectromètres de mobilité ionique et le service de chiens pisteurs. L'ADRC a précisé que les agents participant à la détection de la contrebande s'occupent non seulement de la lutte antidrogues, mais de la contrebande en général – quoique l'interdiction des drogues illicites ait constitué sa principale priorité. Le rapport 2001 de la vérificatrice générale estimait que l'Agence avait consacré entre 14 et 36 millions $ pour faire exécuter la loi visant à interdire les drogues illicites.[13]

Les données que nous présentons ci-dessous proviennent des sources suivantes :

- GRC (services de la police fédérale) : rapport 2001 de la vérificatrice générale et témoignage devant le comité ;
- Forces provinciales et municipales, ainsi que la GRC (sous contrat) : en multipliant par un facteur de 3,5 % (correspondant à la proportion en 2001 des infractions à la LRDS, soit 91 920 infractions, par rapport au total des infractions au Code Criminel, soit 2 534 319 infractions et à la LRDS pour un total de 2 626 239

[12] *Ibid.*, page 33.

[13] *Rapport de la vérificatrice générale du Canada à la Chambre des communes*, 2001, chapitre 11, « Les drogues illicites : le rôle du gouvernement fédéral » page 16.

infractions)[14] les dépenses totales de 5,0 milliards $ des agences d'application de la loi (en 1997-1998, les dépenses ont totalisé 4,8 milliards $ - excluant les dépenses de la GRC, le service de police du fédéral)[15] ; et

- ADRC – selon une estimation réalisée à partir des chiffres apparaissant dans le Rapport de 2001 de la vérificatrice générale (de 14 à 36 millions $) et le témoignage de l'ADRC devant le comité (75 millions $).

Admettant qu'il s'agit là d'une méthode de calcul brute et non scientifique qui ne tient pas compte de facteurs qui pourraient certainement justifier des ajustements, elle nous permet tout de même d'avoir une meilleure idée des coûts d'application de la loi en matière de drogues illicites au Canada.

GRC (services fédéraux)	164 millions $
Polices provinciale et municipales	175 millions $
ADRC	50 millions $
Total	**389 millions $**

Compte tenu du fait que les enquêtes sur les drogues font appel à des ressources extrêmement importantes, il est permis de penser que la lutte antidrogues représente bien plus que 3,5 % du budget de la police, le chef Fantino ayant même suggéré qu'elle pouvait atteindre 33 % de son budget. Si nous utilisions un facteur de 15 %, cela porterait le coût des services provinciaux et municipaux en matière de drogues illicites à 750 millions $. **C'est dire qu'au total, on consacrerait, chaque année, la somme de presque 1milliard $ à la lutte antidrogues.** Il est évident qu'on ne pourrait récupérer tous ces coûts, même sous un régime de légalisation, puisque les forces policières redirigeraient sûrement les ressources vers d'autres priorités. Cependant, on pourrait s'attendre raisonnablement à des économies importantes si on assouplissait les lois relatives au cannabis.

> *« ...les économies en termes de coûts d'exécution de la loi si on décriminalisait la possession sont difficiles à estimer. La difficulté repose en partie sur le fait que le nombre d'arrestations attribuables au cannabis a diminué au cours des dernières années à Vancouver, ce qui reflète la tendance globale qui vise à relâcher l'exécution de la loi dans les cas de simple possession. Néanmoins,* ***les activités d'une exécution plus lâche de la loi permettraient des économies substantielles si on abrogeait ou si on modifiait la loi*** *»*[16] *(nous soulignons)*

---

[14] Statistiques Canada, Centre canadien de la statistique juridique, *Juristat*, Statistiques de la criminalité au Canada - 2001, page 14.

[15] Statistiques Canada, Centre canadien de la statistique juridique, *Juristat*, Statistiques de la criminalité au Canada - 2001, page 14.

[16] Kash Heed, section des drogues, Délibérations du Comité spécial sur les drogues illicites, Sénat canadien, première session de la trente-septième législature, 2001, numéro 10, page 62.

POUVOIRS POLICIERS[17]

D'aucuns disent que l'on a accordé à la police des pouvoirs beaucoup trop vastes pour l'exécution de la loi en matière de drogues et que, dans la lutte antidrogues, la société en est venue à tolérer toute une batterie de techniques d'enquête – écoute électronique, fouilles à nu, recours à des indicateurs rémunérés, provocation policière, etc. – qui heurtent nos notions fondamentales de liberté civile. Tenant compte du fait qu'il soit plus difficile d'appliquer la loi en raison de la nature même des infractions liées à la drogue, cette section examine les décisions rendues par les tribunaux sur les pouvoirs et méthodes inusitées demandées par les services de police dans ces cas. Le recours à des pouvoirs policiers spéciaux pour l'exécution de la loi en matière de drogue a une longue histoire comme nous l'avons vu au chapitre 12, mais cette section porte sur la situation contemporaine.

On s'entend en général pour dire que la police a besoin de pouvoirs pour faire respecter la loi et maintenir l'ordre dans notre société. Lorsqu'elle enquête sur des actes criminels, la police peut employer des techniques d'enquête moins intrusives comme l'observation et l'interrogatoire. Dans d'autres cas, elle peut devoir employer des méthodes plus intrusives comme la surveillance électronique et la vente surveillée. Ces méthodes, bien qu'elles soient aussi appliquées à l'égard d'autres actes criminels, sont utilisées beaucoup plus fréquemment dans les enquêtes visant les drogues.

Il faut toutefois limiter ces pouvoirs pour protéger les personnes contre les actions policières excessives. Comme le juge La Forest l'avait formulé : « *L'interdiction qui est faite au gouvernement de s'intéresser de trop près à la vie des citoyens touche à l'essence même de l'État démocratique.* »[18] Pour déterminer si la conduite de la police est acceptable, il faut généralement tenir compte d'intérêts conflictuels. Il y a d'une part les intérêts individuels, et notamment le droit de ne pas être soumis aux ingérences de l'État, et d'autre part les intérêts de l'État, et notamment son devoir de protéger la société. Lorsque ces intérêts s'opposent, il peut être parfois difficile de s'entendre sur la ligne de démarcation à adopter concernant la conduite de la police.

Les tribunaux savent que, à mesure que les crimes deviennent plus subtils, il faut que la police puisse employer des techniques d'enquête plus perfectionnées pour les dépister. De plus, dans le cas des infractions liées aux drogues et à d'autres infractions de nature consensuelle[19], on sait que les techniques d'enquête ordinaires sont souvent insuffisantes en raison de la difficulté à dépister ces activités. En général, comme il n'y

---

[17] Cette section s'inspire largement du rapport de recherche préparé pour le Comité par la Division de la recherche parlementaire : Lafrenière G., (2001) *Les infractions aux drogues et les pouvoirs policiers.* Ottawa: Bibliothèque du Parlement. Disponible sur le site du Comité à www.parl.gc.ca/drogues-illicites.asp

[18] R. c. *Dyment*, (1988) 45 C.C.C. (3d) 244, p. 254 (C.S.C.).

[19] Signalons parmi les infractions consensuelles les paris et la prostitution.

a pas de «victimes », il n'y a personne pour porter plainte ou signaler un crime à la police. Le Parlement et les tribunaux semblent convenir qu'il peut être justifié d'accorder des pouvoirs supplémentaires à la police dans ces circonstances. On estime que la police doit agir de façon proactive au lieu de réagir comme elle le fait généralement dans le cas des infractions non consensuelles. Un exemple de ce point de vue est exprimé dans la déclaration suivante de l'ancien juge en chef Laskin de la Cour suprême du Canada :

> *« Le mode de dépistage des actes criminels réels ou soupçonnés, et de leurs auteurs, varie nécessairement avec le genre de crime. Par exemple, lorsqu'il y a violence ou introduction par effraction et vol, il existe généralement des preuves manifestes de l'infraction que la police peut utiliser pour retrouver les coupables ; il est fréquent que la victime, sa famille ou le propriétaire du bien, selon le cas, appelle la police et lui fournisse des indices facilitant son enquête. Lorsqu'il s'agit de crimes « consensuels », c'est-à-dire de crimes impliquant des personnes consentantes, comme dans le cas de la prostitution, des paris illégaux et de la drogue, les méthodes ordinaires ne suffisent plus. Les participants, qu'ils s'estiment lésés ou non, ne portent pas plainte et ne cherchent pas à obtenir le secours de la police ; c'est justement ce qu'ils veulent éviter. Si la police veut réprimer ces infractions que l'opinion publique désapprouve et qui sont d'ailleurs punies dans notre droit, elle doit prendre des initiatives. »* [20]

La Commission Le Dain a aussi admis la nature particulière des infractions liées à la drogue :

> *« L'exécution des lois concernant les stupéfiants est rendue très difficile par la nature même des délits tombant sous le coup de ces lois, et notamment par le fait que les personnes impliquées sont consentantes et agissent de concert, et aussi parce qu'il y a rarement sinon jamais de victime ayant un sujet de plainte, comme dans le cas des délits contre la personne ou la propriété. La police reçoit rarement l'aide de plaignants. C'est à elle qu'il incombe en majeure partie d'établir la preuve de l'accusation. En outre, l'activité se rattachant à l'usage non médical des drogues est relativement facile à dissimuler. Les parties intéressées peuvent, d'un commun accord, l'exercer dans des lieux qui échappent à la surveillance de la police. Il est également facile de cacher les substances et les instruments incriminables ou de s'en débarrasser.*
>
> *Toutes ces difficultés ont progressivement nécessité le recours à des méthodes exceptionnelles d'exécution de la loi. »* [21]

Fouilles perquisitions et saisies

Les pouvoirs spéciaux de fouille, de perquisition et de saisie font depuis longtemps partie de l'exécution de la loi en matière de drogues illicites. Ainsi, avant d'être abrogés en 1985, les mandats de main-forte donnaient aux agents de la paix le

---

[20] R. c. *Kirzner* (1977) 38 C.C.C. (2d) 131 (C.S.C.), page 135.

[21] Rapport de la Commission d'enquête sur l'usage des drogues à des fins non médicales, *Le cannabis*, Ottawa, 1972, page 239.

pouvoir de perquisitionner sans avoir préalablement obtenu un mandat. Ces pouvoirs étaient prévus dans les versions antérieures de la *Loi sur les douanes*, de la *Loi sur l'accise*, de la *Loi sur les aliments et drogues* et de la *Loi sur les stupéfiants*. Avant son abrogation en 1985, le paragraphe 10(1) de la *Loi sur les stupéfiants* permettait aux agents de la paix intervenant en vertu du « pouvoir d'un mandat de main-forte ou d'un mandat » d'entrer dans une maison d'habitation et de la fouiller « à toute heure » pourvu que l'agent de la paix ait des motifs valables de croire qu'il se trouvait des stupéfiants dans la maison « au moyen desquels ou à l'égard desquels » une infraction avait été commise aux termes de la *Loi*. L'article 8 de la Charte a finalement mis un terme aux mandats de main-forte.

De nos jours, c'est la LRDS qui énonce toutes les conditions de fouille, perquisition et saisie dans le cas des infractions liées aux drogues. Bien que ces dispositions soient semblables à celles du *Code criminel* en la matière, la police jouit de pouvoirs supplémentaires en vertu des lois s'appliquant aux drogues illicites. Le paragraphe 11(1) de la LRDS permet à un juge de délivrer un mandat de perquisition s'il estime, selon l'information qui lui est fournie sous serment, qu'il existe des motifs valables de croire que les articles recherchés se trouvent bien là. Ces articles sont les suivants :

- Une substance désignée ou un précurseur ayant donné lieu à une infraction à la LRDS ;
- Une chose qui contient ou recèle une substance désignée ou un précurseur visé à l'alinéa précédent ;
- Un bien infractionnel ;
- Une chose qui servira de preuve relativement à une infraction à la LRDS.

Il est possible d'obtenir un mandat même s'il n'y a pas de raison de croire qu'il y a de la drogue sur les lieux perquisitionnés, pourvu qu'il y ait des motifs de croire qu'il s'y trouve l'un des trois autres types de « choses ».

La LRDS autorise une perquisition « **à tout moment** ». Il n'est donc pas nécessaire d'obtenir l'autorisation de perquisitionner de nuit, comme l'exige le *Code criminel*.

Un autre pouvoir spécial est prévu au paragraphe 11(5) de la LRDS qui permet à la police **de procéder à des fouilles corporelles** dans certaines circonstances. Ce pouvoir n'est pas prévu au *Code criminel*, bien que la police ait le pouvoir, selon la *common law*, de fouiller une personne arrêtée. La LRDS donne à la police, dans le cadre de l'exécution d'un mandat, le pouvoir de chercher sur une personne une substance désignée ou d'autres articles prévus dans la disposition. Cela n'est possible que si le policier a des motifs raisonnables de croire que la personne trouvée sur les lieux désignés par le mandat a en sa possession une substance désignée ou d'autres articles énumérés dans le mandat. Cette disposition autorise donc la police à fouiller une personne même s'il n'y a pas eu d'arrestation, mais seulement pour ce qui est de certains articles et seulement si le policier a des motifs raisonnables.

Le paragraphe 11(7) permet à la police d'exercer sans mandat les pouvoirs que lui confèrent les paragraphes 11(1), (5) ou (6) en matière de perquisition « lorsque l'urgence de la situation rend son obtention difficilement réalisable, sous réserve que les conditions de délivrance en soient réunies ». Comme nous le verrons plus loin, les perquisitions sans mandat sont considérées par principe comme non raisonnables, mais les tribunaux prévoient certaines exceptions. Les règles en ont été résumées comme suit :

> [Traduction] *« Une perquisition sans mandat se justifie lorsque, compte tenu de la situation, il n'est pas possible d'obtenir un mandat, par exemple si c'est un véhicule, un aéronef ou tout autre moyen de transport susceptible de changer d'endroit qui fait l'objet de la fouille. C'est à l'État que revient alors la responsabilité de prouver que l'obtention d'un mandat dans les circonstances de l'espèce aurait compromis l'efficacité de l'exécution de la loi.*
>
> *Lorsqu'il n'existe pas de pouvoir de fouille en common law concernant les fouilles en «situation d'urgence», les tribunaux estiment qu'il est nécessaire que la loi habilitante fasse état d'un pouvoir de perquisition sans mandat dans certaines circonstances, par exemple en situation d'urgence. Ces dispositions législatives devraient définir étroitement le type d'enquête qui permettrait le recours à une perquisition sans mandat. »*[22]

Si la présence de drogues dans un véhicule peut être considérée comme une situation d'urgence, les tribunaux n'ont pas encore déterminé avec certitude si la perquisition sans mandat d'un domicile privé dans le cadre d'une situation d'urgence satisfait aux exigences constitutionnelles.[23] Les tribunaux exigeront que la question d'intérêt public invoquée soit suffisamment impérieuse pour l'emporter sur le droit à la vie privée associé au domicile d'un particulier, par exemple s'il s'agit de sauver une vie humaine ou de sécurité.[24]

La *Loi* permet également à l'agent de police de saisir d'autres choses que celles qui sont énumérées dans le mandat s'il a des motifs raisonnables de croire qu'il s'agit d'articles énumérés au paragraphe 11(1)[25] et à l'agent de police de saisir toute chose dont il a des motifs raisonnables de croire qu'elle a été obtenue ou utilisée dans le cadre de la perpétration d'une infraction (pas uniquement liée aux drogues) ou qu'elle servira de preuve à l'égard de celle-ci.[26]

La LRDS traite aussi du recours à la force. L'article 12 prévoit que l'agent de la paix exécutant un mandat peut «recourir à l'assistance qu'il estime nécessaire » et « à la force justifiée par les circonstances ». Rappelons que les dispositions du *Code criminel* en

---

[22] Brucker, T., (2002) *The Practical Guide to the Controlled Drugs and Substances Act*, 3e édition, Carswell, page 101.

[23] Dans R. c. *Feeney*, la Cour suprême du Canada a refusé d'aborder la question puisque, selon elle, il n'y avait pas de circonstances pressantes au moment de l'arrestation.

[24] R. c. *Godoy*, (1999) 131 C.C.C. (3d) 129 (C.S.C.).

[25] Voir la *Loi réglementant certaines drogues et autres substances*, paragraphe 11(6).

[26] Voir la *Loi réglementant certaines drogues et autres substances*, paragraphe 11(8).

matière de fouille et de perquisition ne précisent pas qu'il est possible de recourir à la force, mais ce recours est prévu ailleurs dans le *Code criminel*.

Les articles saisis en vertu de la LRDS sont soit des biens infractionnels (de l'argent, des automobiles, etc.) ou des substances désignées (des « drogues »), des règles précises s'appliquant à la détention et à la confiscation dans chaque catégorie. La *Loi* prévoit également la fouille, la saisie, la détention et la confiscation des produits de la criminalité relativement aux infractions liées aux drogues en intégrant des dispositions du *Code criminel* à cet égard.

Article 8 de la Charte – perquisitions sans mandat

L'article 8 de la Charte prévoit que chacun a droit à la protection contre les fouilles, les perquisitions ou les saisies abusives. Certaines décisions rendues ont trait à la question de savoir si les perquisitions sont des mesures raisonnables dans telle ou telle situation et à la question accessoire de savoir si les éléments de preuve ainsi obtenus peuvent être produits au procès. Comme nous le verrons plus en détail, une perquisition est généralement considérée comme raisonnable si elle est autorisée par la loi, si la loi elle-même est raisonnable et si la perquisition est effectuée de manière raisonnable.

L'article 8 protège le public contre les ingérences de l'État en vertu du principe de l'attente raisonnable en matière de vie privée. Lorsqu'il n'y a pas attente raisonnable en matière de vie privée, l'article 8 ne s'applique pas. Par ailleurs, une diminution de l'attente raisonnable en matière de vie privée (p. ex. dans les prisons ou aux frontières) abaisse le seuil du caractère raisonnable (p. ex. en justifiant l'absence de mandat ou en réduisant la norme applicable à la justification de la perquisition). Le domicile privé est le lieu où l'attente raisonnable en matière de vie privée est la plus élevée et pour lequel la protection constitutionnelle est également la plus élevée.

La *Charte* n'exige pas expressément que la police obtienne un mandat avant de procéder à une perquisition, mais la Cour suprême du Canada, dans l'affaire *Hunter* c. *Southam Inc.*, a établi la présomption qu'une perquisition sans mandat n'est pas raisonnable.[27] Règle générale, pour qu'une perquisition soit valide, la police doit obtenir une autorisation préalable (par exemple un mandat de perquisition) et invoquer des motifs raisonnables et probables pour justifier la demande, afin d'assurer une protection contre une ingérence de l'État non justifiée.

Il s'agit là de la règle générale, mais il y a des exceptions. On sait qu'il n'est pas toujours possible de demander une autorisation préalable. À l'égard de ces exceptions, les tribunaux exigent qu'un pouvoir de perquisition sans mandat soit prévu, par la loi ou la *common law*. Mais l'existence de ce pouvoir ne suffit pas, car les tribunaux l'évalueront également pour s'assurer qu'il est raisonnable. Définissant ce qui doit être considéré comme raisonnable, les tribunaux ont conclu que les perquisitions sans mandat doivent

[27] *Hunter (directeur des enquêtes et recherches)* c. *Southam Inc.* (1984) 14 C.C.C. (3d) 97 (C.S.C.).

généralement être autorisées « *seulement lorsqu'une situation d'urgence rend pratiquement impossible l'obtention d'un mandat* ».[28] Dans R. c. *Grant*, la Cour a déclaré que :

> « *En résumé, l'article 10 peut validement permettre d'effectuer une fouille, une perquisition ou une saisie sans mandat en cas de situation d'urgence qui rend pratiquement impossible l'obtention d'un mandat. On jugera généralement qu'il y a situation d'urgence s'il existe un risque imminent que les éléments de preuve soient perdus, enlevés, détruits ou qu'ils disparaissent si la fouille, la perquisition ou la saisie est retardée. La croyance que des éléments de preuve recherchés se trouvent à bord d'un véhicule à moteur, d'un navire, d'un aéronef ou de tout autre véhicule rapide créera souvent une situation d'urgence ; toutefois, il n'existe aucune exception générale pour ces moyens de transport.* »[29]

Chaque cas est étudié au mérite, mais plus le degré d'urgence indiqué par la police dans les circonstances sera élevé, plus le tribunal aura tendance à considérer raisonnable la perquisition sans mandat.

Fouilles d'une personne

En dehors de quelques dispositions particulières comme celle que l'on trouve dans la LRDS, le droit pénal fédéral ne prévoit pas d'autorisation pour la fouille d'une personne. Ceci dit, la *common law* prévoit effectivement la fouille accessoire à une arrestation légale. Ce pouvoir de *common law* est une exception à la règle générale qui veut qu'une fouille soit précédée d'une autorisation pour être jugée raisonnable. C'est une exception fort importante, car la plupart des fouilles corporelles sont effectuées en vertu de ce pouvoir. Comme nous l'avons expliqué, la LRDS permet effectivement au policier qui exécute un mandat de perquisition en vertu de la *Loi* de fouiller les personnes présentes sur les lieux à certaines conditions.

En vertu de ce pouvoir prévu par la *common law*, une personne ne peut être fouillée qu'après avoir été arrêtée et seulement dans le but de trouver d'autres éléments de preuve relatifs aux accusations qui sont portées contre elle ou une arme ou un article quelconque qui lui permettrait de se sauver ou de commettre un acte de violence. Bien que la fouille accessoire à une arrestation soit un pouvoir assez large, il n'y a pas de droit automatique et illimité de fouiller accessoirement à une arrestation.

Le mode de fouille

Les tribunaux se sont montrés disposés à examiner de très près la manière dont la fouille d'une personne est effectuée. Par exemple, dans l'affaire *Collins*, une cause jugée en Colombie-Britannique, l'accusée était assise à un bar qui était censément fréquenté par des trafiquants d'héroïne et leurs clients. Elle avait été saisie par deux policiers : l'un d'eux l'avait prise par la gorge, la rendant à demi inconsciente, tandis que l'autre lui avait ouvert la bouche de force. Pendant ce temps, trois capsules d'héroïne s'étaient échappées de sa main droite. La Cour a estimé que les agents de police n'avaient pas,

---

[28] R. c. *Grant* (1993) 84 C.C.C. (3d) 173 (C.S.C.), page 188.
[29] *Ibid.*, page 189.

en l'espèce, de motifs raisonnables et probables de croire que l'accusée avait des narcotiques dans la bouche et elle a donc conclu que la fouille n'était pas légale. Elle a ajouté et conclu que l'admission en preuve de ces éléments porterait atteinte à la réputation de l'administration de la justice car cela reviendrait à couvrir et à permettre la perpétuation d'une conduite inacceptable de la part de la police. Cette décision a été confirmée en appel par la Cour suprême du Canada. Cela ne signifie pas qu'une « prise à la gorge » soit nécessairement toujours jugée inacceptable. Dans l'affaire R. v. *Garcia Guiterrez*[30], [Traduction] « *une prise à la gorge avait permis d'empêcher que des éléments de preuve soient avalés et un coup de poing au plexus avait permis de contraindre le suspect à les cracher. Sous réserve d'une opinion dissidente vigoureusement formulée, la majorité de la Cour d'appel de la Colombie-Britannique a conclu que la prise à la gorge en vue de préserver des éléments de preuve était acceptable dans les circonstances de l'espèce* ».[31]

Les lois ou règles de *common law* autorisant la fouille de personnes ne disent généralement rien de la portée qu'elles supposent à la fouille en question. Comme nous l'avons vu précédemment, l'une des conditions d'une fouille jugée valable est qu'elle doit être effectuée de façon raisonnable. En ce qui a trait à la fouille d'une personne, le degré d'indiscrétion peut être tel que la fouille sera considérée comme abusive.

Analysant la question des fouilles corporelles aux frontières, la Cour suprême du Canada a distingué trois catégories de fouilles :

> « *Il est, à mon avis, significatif que la jurisprudence et la doctrine semblent distinguer trois types de fouilles à la frontière. Premièrement, il y a l'interrogatoire de routine auquel est soumis chaque voyageur à un port d'entrée, lequel est suivi dans certains cas d'une fouille des bagages et peut-être même d'une fouille par palpation des vêtements extérieurs. Il n'y a rien d'infamant à être l'un des milliers de voyageurs qui font, chaque jour, l'objet de ce type de contrôle de routine à leur entrée au Canada et aucune question constitutionnelle n'est soulevée à cet égard. Il serait absurde de laisser entendre qu'une personne qui se trouve dans une telle situation est détenue au sens constitutionnel du terme et a le droit, en conséquence, d'être informée de son droit à l'assistance d'un avocat. Le second type de fouille effectuée à la frontière est la fouille à nu comme celle à laquelle a été soumise l'appelante en l'espèce. Cette fouille est effectuée dans une pièce fermée, après un examen secondaire et avec la permission d'un agent des douanes occupant un poste d'autorité. Le troisième type de fouille, celui qui comporte l'empiètement le plus poussé, est parfois appelé examen des cavités corporelles ; pour ce genre de fouille, les agents des douanes ont recours à des médecins, à des rayons X, à des émétiques, ainsi qu'à d'autres moyens comportant un empiètement des plus poussés.* »[32]

Dans l'affaire *Simmons*, le juge en chef Dickson a ajouté que les différents types de fouille soulèvent des problèmes différents et des questions d'ordre constitutionnel entièrement différentes « *puisqu'il est évident que plus l'empiètement sur la vie privée est important, plus sa justification et le degré de protection constitutionnelle accordée doivent être*

---

[30] (1991) 65 C.C.C. (3d) 15 (B.C.C.A.).

[31] Fontana, J.A., (1997) *The Law of Search and Seizure in Canada*, 4e édition, Butterworths, page 396.

[32] R. c. *Simmons*, (1988) 45 C.C.C. (3d) 296 (C.S.C.).

importants ».[33] Cette perspective a été confirmée en 1999 par la Cour suprême du Canada dans l'affaire *Monney* (discutée *infra*). Dans les deux cas, la question de la constitutionnalité de la troisième catégorie de fouille est restée sans réponse, tandis que les deux premières ont été jugées raisonnables en vertu de l'article 8, même si elles sont fondées sur le seul soupçon. Rappelons que ces causes ont trait aux fouilles effectuées aux frontières.

La Cour suprême du Canada a précisé ce qui suit concernant les fouilles sommaires accessoires à une arrestation :

> *« Jaugeant l'intérêt public dans l'application efficace et sécuritaire de la loi à la lumière de l'intérêt public d'assurer le respect de la liberté et de la dignité des individus, j'estime que la fouille sommaire accessoire à une arrestation légale concilie ces deux impératifs en ce que l'intrusion minimale que représente la fouille est nécessaire pour assurer une saine administration de la justice criminelle. »* [34]

Ainsi, lorsque la fouille d'une personne est justifiée, une fouille sommaire sera généralement jugée raisonnable car c'est probablement le mode de fouille le moins indiscret.

La question des fouilles à nu a été examinée dans R. c. *Flintoff*.[35] Dans cette affaire, un policier avait arrêté l'accusé sur la scène d'un accident pour conduite en état d'ébriété. L'accusé avait été soumis à une fouille à nu avant de passer l'alcootest, conformément à une politique générale de la police exigeant que tous les policiers procèdent à une fouille à nu de toutes les personnes placées en détention au poste, quelles que soient les circonstances de l'affaire ou la situation de la personne en question. La Cour a estimé que la fouille était abusive et qu'elle portait atteinte aux droits garantis par l'article 8 de la *Charte*. Elle a déclaré que la fouille à nu n'était pas justifiée en droit et qu'elle n'était pas accessoire à une arrestation, précisant que l'atteinte aux droits était « *scandaleuse* » et « *flagrante* » et qu'elle choquerait la population. Selon la Cour, la fouille à nu est [Traduction] « *l'un des types de fouille les plus indiscrets et « l'un des modes les plus extrêmes de l'exercice du pouvoir de la police* ». La police peut procéder à une fouille accessoirement à une arrestation, mais [Traduction] « *le degré d'intrusion doit être raisonnable et justifié par un objectif valable, la sécurité par exemple* ».

Dans l'arrêt R. c. *Golden*[36] la Cour Suprême revoit les questions entourant les fouilles dans les cas d'arrestation et la façon dont on peut procéder à une telle fouille. M. Golden a été arrêté suite à ce que la police considérait comme des transactions de stupéfiants dans un restaurant. Il a été amené vers un escalier où la police a descendu ses pantalons et ses sous-vêtements et remarqué un petit sachet de plastique transparent contenant une substance blanche au niveau de la région anale. La police a tenté de le récupérer, mais l'accusé a résisté. Il a été escorté au restaurant et les policiers ont

---

[33] *Ibid.*

[34] *Cloutier* (1990) 53 C.C.C. (3d) 257 (C.S.S.), pages 277-278.

[35] (1998) 126 C.C.C. (3d) 321 (Ont. C.A.).

[36] 2001 SCC 83.

demandé aux clients de quitter les lieux. Ils ont alors forcé l'accusé à se pencher sur une table et descendu ses pantalons et son sous-vêtement. Il a continué de résister aux tentatives de la police visant à récupérer le sachet de plastique et a accidentellement déféqué – ce qui n'a pas libéré le sachet de plastique. Les policiers ont pris une paire de gants de caoutchouc servant à laver la vaisselle et retiré le sachet alors que l'accusé reposait face contre le sol. On a procédé à nouveau à une fouille à nu de l'accusé au poste de police. Voici ce que la Cour suprême a déclaré concernant les fouilles à nu :

> *« Alors que le répondant et les intervenants de la Couronne ont tenté de réduire le caractère intrusif des fouilles à nu, nous considérons qu'elles représentent sans aucun doute une atteinte flagrante à la vie privée et qu'elles constituent souvent une expérience humiliante, dégradante et traumatisante pour l'individu qui en fait l'objet. On peut clairement réduire les effets négatifs de la façon dont on procède aux fouilles à nu, mais même la façon la plus sensible de procéder à ces fouilles est très indiscrète. De plus, nous croyons qu'il est important de noter les présentations de l'ACLC et de l'ALST à l'effet que les Afro-canadiens et les peuples autochtones sont surreprésentés dans le système de justice pénale et, par conséquent, qu'ils sont susceptibles de représenter une part disproportionnée des gens que la police arrête et qu'on soumet à des fouilles personnelles, incluant des fouilles à nu… Ainsi, on se doit d'élaborer un cadre approprié afin de régir les fouilles à nu pour empêcher ces fouilles inutiles et injustifiées avant qu'elles ne se produisent. »*[37]

Dans *Golden*, la Cour suprême du Canada a observé que la Couronne n'avait pas démontré que la fouille à nu de l'appelant avait été effectuée de façon raisonnable. Elle a soutenu que la preuve n'avait pas établi que cette situation justifiait une fouille à nu à l'extérieur du poste de police, surtout que le poste n'était situé qu'à deux minutes. La Cour a donc conclu qu'il ne s'agissait pas d'un cas impliquant un besoin urgent et essentiel de procéder à une fouille à nu « sur le terrain » dans le but de préserver la preuve.

La Cour suprême a également mis en garde contre le recours à la force lors des fouilles :

> *« Nous rejetons tout particulièrement la suggestion à l'effet que l'absence de coopération et la résistance de la personne arrêtée autorise la police à adopter un comportement ignorant ou compromettant son intégrité et sa sécurité physiques et psychologiques. Si on ne s'en tient pas à l'approche générale articulée dans ce cas, il n'est aucunement nécessaire qu'on collabore à cette violation de la Charte des droits. Tout recours à la force ou à la violence doit être nécessaire et proportionnel dans chaque circonstance particulière. Dans ce cas, le refus de l'appelant de remettre la preuve ne justifie ou n'atténue aucunement le fait qu'on ait mené la fouille dans un endroit public et d'une façon méprisant considérablement sa dignité et son intégrité physique, et ce, malgré l'absence de raisons raisonnables et probables ou de circonstances exigeantes. »*[38]

---

[37] *Ibid.*, para. 83.
[38] *Ibid.*, para. 116.

Le cas *Golden* est important en ce sens que la Cour suprême a adopté un «cadre devant permettre à la police de décider de la meilleure façon de procéder à une fouille à nu pour que l'arrestation se déroule conformément à la *Charte.* » Ce cadre doit inclure les questions suivantes :

1. *La fouille à nu peut-elle avoir lieu au poste de police et, sinon, pourquoi pas ?*
2. *La fouille à nu se déroulera-t-elle de façon à assurer la santé et la sécurité de toutes les personnes concernées ?*
3. *La fouille à nu sera-t-elle autorisée par un agent de police jouissant d'un pouvoir de surveillance ?*
4. *S'est-on assuré que le ou les agents de police procédant à la fouille à nu soient du même sexe que l'individu subissant cette fouille ?*
5. *Le nombre d'agents de police impliqués dans la fouille ne sera-t-il que le minimum nécessaire dans les circonstances ?*
6. *Quelle est la force minimale qu'on doit employer pour procéder à la fouille à nu ?*
7. *Procédera-t-on à la fouille à nu dans un endroit privé de façon à ce que personne autre que les individus y prenant part ne puissent l'observer ?*
8. *La fouille à nu se déroulera-t-elle le plus rapidement possible et de façon à assurer que la personne ne soit en aucun temps complètement nue ?*
9. *La fouille à nu ne consistera-t-elle que dans une inspection visuelle des organes génitaux et de la région anale de la personne arrêtée sans qu'il n'y ait de contact physique ?*
10. *Si l'inspection visuelle révèle la présence d'une arme ou de tout autre élément de preuve dans une cavité corporelle (excluant la bouche), donnera-t-on au détenu le choix de retirer lui-même l'objet ou de le faire enlever par un p rofessionnel formé dans le domaine médical ?*
11. *Rédigera-t-on un rapport adéquat des raisons pour lesquelles on a procédé à une fouille à nu et de la façon dont celle-ci s'est déroulée ?*

Étant donné la nature des infractions liées aux drogues et le fait que ces substances sont plus faciles à dissimuler, il semblerait que des fouilles plus indiscrètes puissent être permises. Les tribunaux sont assurément conscients des tactiques employées par les contrevenants pour dissimuler des drogues et ils peuvent être plus disposés à autoriser la police à agir d'une façon qui, dans d'autres circonstances, ne serait pas jugée acceptable. Il est clair cependant, d'après les décisions rendues par les tribunaux, que plus la fouille est indiscrète, plus elle doit être justifiée et plus la protection constitutionnelle joue.

Écoles

Dans R. c. *M. (M.R.)*,[39] une majorité de la Cour suprême du Canada a également statué que l'attente raisonnable en matière de vie privée est « *beaucoup moindre* » pour les élèves à l'école parce que les autorités scolaires ont la responsabilité «*de procurer un environnement sûr et de maintenir l'ordre et la discipline dans l'école* ». Les autorités scolaires (pas la police) peuvent procéder à des fouilles sans mandat : il leur suffit d'avoir des motifs raisonnables de croire certains faits (et non des motifs raisonnables et probables). Ces

[39] [1998] 3 R.C.S. 393.

autorités ne doivent cependant pas être des agents de police. La Cour a ajouté que les élèves doivent savoir que « *cela peut parfois commander la fouille d'élèves et de leurs effets personnels de même que la saisie d'articles interdits* ». En conclusion, la Cour a déclaré que la saisie de marijuana sur un élève fouillé au cours d'une danse à l'école n'enfreignait pas ses droits aux termes de l'article 8 de la *Charte*. Bien qu'elle ait établi les paramètres applicables aux fouilles raisonnables sans mandat dans ces circonstances, rappelons que la majorité a expressément limité ses conclusions au contexte des écoles primaires et secondaires et qu'il « n'a pas été question » des collèges et des universités.

Frontières

Les fouilles effectuées par les douaniers à la frontière sont un exemple de réduction des garanties constitutionnelles pour lesquelles les tribunaux considèrent qu'il y a une moindre attente en matière de vie privée en raison du contexte. Dans ce cas, les normes énoncées dans l'affaire *Hunter* peuvent ne pas s'appliquer.

L'article 98 de la *Loi sur les douanes*[40] permet aux douaniers de fouiller, dans un délai raisonnable, une personne qui vient d'arriver au Canada ou qui est sur le point de le quitter s'il a des motifs raisonnables de soupçonner qu'elle dissimule des articles illégaux sur elle. La Cour suprême du Canada a interprété cette norme du point de vue du soupçon raisonnable et non de la norme plus élevée des motifs raisonnables.[41] Toute personne sur le point d'être fouillée peut demander à voir un agent supérieur qui décidera si la fouille doit avoir lieu.[42]

Dans l'affaire R. c. *Simmons*[43], l'accusée avait été tenue de se soumettre à une fouille à nu parce qu'un douanier était convaincu qu'elle transportait des articles de contrebande. La décision de la Cour a confirmé le droit du Canada, à titre d'État souverain, de contrôler qui et ce qui traverse ses frontières. Le pouvoir de fouille en question ne remplissait pas les critères énoncés dans l'affaire *Hunter* (p. ex. autorisation préalable et motifs raisonnables), mais la Cour n'en a pas moins déclaré ce qui suit :

> « *J'accepte la proposition de la poursuite que les attentes raisonnables en matière de vie privée sont moindres aux douanes que dans la plupart des autres situations. En effet, les gens ne s'attendent pas à traverser les frontières internationales sans faire l'objet d'une vérification. Il est communément reconnu que les États souverains ont le droit de contrôler à la fois les personnes et les effets qui entrent dans leur territoire. On s'attend à ce que l'État joue ce rôle pour le bien-être général de la nation. Or, s'il était incapable d'établir que tous ceux qui cherchent à traverser ses frontières ainsi que leurs effets peuvent légalement pénétrer dans son territoire, l'État ne pourrait pas remplir cette fonction éminemment importante. Conséquemment, les voyageurs qui cherchent à traverser des frontières internationales s'attendent parfaitement à faire l'objet d'un processus d'examen. Ce processus se caractérise par la production des pièces d'identité et des documents de voyage requis, et il implique une fouille qui commence*

[40] S.C. 1986 ch.6.

[41] R. c. *Monney*, (1999) 133 C.C.C. 129 (C.S.C.).

[42] La *Loi sur les douanes* comporte également d'autres dispositions relatives aux pouvoirs des douaniers. Il n'en est pas question ici.

[43] (1988) 45 C.C.C. 296 (C.S.C.).

par la déclaration de tous les effets apportés dans le pays concerné. L'examen des bagages et des personnes est un aspect accepté du processus de fouille lorsqu'il existe des motifs de soupçonner qu'une personne a fait une fausse déclaration et transporte avec elle des effets prohibés.

À mon sens, l'interrogatoire de routine auquel procèdent les agents des douanes, l'examen des bagages, la fouille par palpation et la nécessité de retirer en privé suffisamment de vêtements pour permettre l'examen des renflements corporels suspects, qui sont autorisés par les rédacteurs des articles 143 et 144 de la Loi sur les douanes, ne sont pas abusifs au sens de l'article 8. En vertu de la Loi sur les douanes, les fouilles personnelles ne sont pas systématiques, elles sont effectuées seulement lorsque les agents des douanes ont raisonnablement lieu de supposer qu'une personne cache sur elle de la contrebande. La décision de procéder à une fouille peut faire l'objet d'une révision à la demande de la personne qui doit être fouillée. Bien qu'à certains égards les fouilles personnelles puissent être gênantes, elles sont effectuées en privé dans des pièces destinées à cette fin, par des agents du même sexe que la personne fouillée. Dans ces conditions, exiger d'une personne qu'elle retire des vêtements jusqu'à ce que la présence ou l'absence d'objets cachés puisse être établie, ce n'est pas attenter à son intégrité physique d'une façon qui puisse être considérée abusive au sens de l'article 8 de la Charte.

Je souligne également que selon les articles en question : (i) avant qu'une personne puisse être fouillée, le préposé ou la personne qui effectue la fouille doit avoir raisonnablement lieu de supposer que la personne qui subit cette fouille peut avoir, cachés sur elle, des effets sujets à déclaration en douane, ou des articles prohibés, et (ii) avant qu'une personne puisse être fouillée, elle a la faculté d'exiger que le préposé la conduise devant un magistrat de police, ou un juge de paix, ou devant le receveur ou le préposé en chef du port ou lieu. Si l'un ou l'autre des susdits constate qu'il n'y a pas de motifs plausibles d'effectuer une fouille, il renvoie cette personne.

Vu les problèmes que pose la répression du trafic illégal des stupéfiants et l'intérêt important qu'a le gouvernement à appliquer nos lois douanières, et étant donné que les attentes en matière de vie privée des gens sont moindres lorsqu'il s'agit de passer une frontière, j'estime que les articles 143 et 144 de la Loi sur les douanes ne sont pas incompatibles avec l'article 8 de la Charte. »[44]

Il convient de noter, aux fins de nos travaux, que la Cour a mentionné les problèmes que soulève le contrôle du trafic des drogues illicites comme facteur d'évaluation du caractère raisonnable de la fouille en vertu de l'article 8 de la *Charte.*

Le fait que l'attente de respect de la vie privée soit moindre aux douanes ne réduit cependant pas l'obligation des autorités de l'État de respecter la *Charte*, même si les motifs qui déclenchent la fouille sont raisonnables et que des drogues sont découvertes durant la fouille. Avant toute fouille, les inspecteurs doivent expliquer clairement au sujet les droits qui sont les siens aux termes de la *Charte*, notamment le droit de consulter un avocat, et son droit de faire examiner la demande de fouille avant de s'y soumettre, comme le prévoit la *Loi sur les douanes.* Dans l'affaire *Simmons*, la suspecte avait été laissée dans l'ignorance de sa situation juridique puisqu'on ne l'avait pas correctement informée de ces droits. La Cour suprême du Canada a donc conclu que la

[44] *Ibid.*, pages 320-321.

fouille n'était pas raisonnable. Les éléments de preuve n'ont cependant pas été exclus puisque les douaniers avaient agi de bonne foi.

La Cour suprême du Canada a déclaré que l'article 98 de la *Loi sur les douanes*, qui autorise les fouilles en vue de découvrir des articles de contrebande « dissimulés sur ou près » de la personne, s'applique aux articles de contrebande qu'un voyageur a ingérés. Dans l'affaire R. c. *Monney*[45], la Cour a conclu qu'un douanier qui a des motifs raisonnables de soupçonner qu'un article de contrebande a été ingéré est autorisé par la *Loi* à détenir le voyageur dans une « salle d'évacuation des drogues » jusqu'à ce que le soupçon puisse être confirmé ou dissipé. Ce type d'intervention revient à une fouille au sens de l'article 8 de la *Charte*, mais la Cour a confirmé que « les attentes raisonnables en matière de vie privée sont moindres aux douanes que dans la plupart des autres situations » et que la fouille en question n'était pas « abusive » en l'occurrence.

La Cour a bien précisé que les différents degrés d'ingérence suscitent des questions d'ordre constitutionnel différentes (p. ex. celle de l'exigence d'une norme supérieure au soupçon raisonnable). Elle a formulé l'avis suivant : « [...] *le risque d'atteinte par l'État à l'intégrité physique d'une personne à l'occasion de fouilles relevant de la troisième catégorie commande le respect de normes de justification constitutionnelle strictes* ».[46]

On voit que les tribunaux appliquent une norme de protection constitutionnelle inférieure dans le cas des fouilles effectuées aux frontières. Comme l'a déclaré la Cour dans l'affaire *Monney*, «les arrêts de notre Cour portant sur le caractère raisonnable d'une fouille ou d'une perquisition pour l'application de l'article 8 en général ne sont pas nécessairement pertinents pour l'appréciation de la constitutionnalité d'une fouille effectuée par des agents des douanes aux frontières canadiennes ».[47]

Surveillance électronique

Comme les infractions liées aux drogues sont consensuelles, la police recourt souvent à des techniques spéciales pour faire enquête sur ce genre de crime, parmi lesquelles figure la surveillance électronique. La Cour suprême a statué que la surveillance électronique constitue une fouille aux fins de l'article 8 de la *Charte*, et ses décisions dans ce secteur ont eu un effet considérable sur les dispositions du *Code criminel* visant de telles techniques. Comme la surveillance électronique est une ingérence plus large dans la vie privée que les perquisitions ordinaires, la loi prévoit des garanties procédurales plus serrées. L'interception clandestine est souvent employée en cas d'infraction liée aux drogues, mais elle peut également l'être dans beaucoup d'autres circonstances où des infractions graves au *Code* et à d'autres lois fédérales sont commises.[48] Le *Rapport annuel sur la surveillance électronique* publié par le Solliciteur général en 1998 indique ce qui suit au sujet de l'importance de la surveillance électronique comme instrument d'enquête :

---

[45] (1999) 133 C.C.C. 129 (C.S.C.).
[46] *Ibid.*, page 152.
[47] *Ibid.*, page 151.
[48] Voir le *Code criminel*, article 183.

« La surveillance électronique est essentielle à la lutte contre le crime organisé, surtout en ce qui concerne le trafic de drogues. Pour réduire l'importation et la distribution de drogues illicites au Canada, les organismes d'application de la loi comptent beaucoup sur l'interception des communications privées. Il est indiqué à la section III du présent rapport que la majorité des autorisations accordées par les tribunaux permettent l'utilisation de la surveillance électronique dans les cas de trafic de substances réglementées. Comme par les années antérieures, nombre de ces autorisations étaient liées à des complots criminels, des crimes qui posent des difficultés à la police lorsqu'il s'agit de les dépister, de faire enquête et de les résoudre.

[...]L'utilisation de la surveillance électronique a permis la saisie de grandes quantités de drogues au Canada. Elle a aussi permis de réduire la disponibilité de drogues dans la rue et dans les collectivités et d'aider à la prévention du crime organisé lié à l'abus de drogue. Sans cet outil essentiel, la capacité des organismes d'application de la loi de prévenir le crime et les dommages sociaux qui s'ensuivent serait considérablement restreinte. »

Il est clair que la surveillance électronique est un instrument d'enquête efficace, mais c'est aussi une sérieuse infraction au droit à la vie privée. Voici ce qu'a déclaré la Cour suprême du Canada à cet égard :

« La surveillance électronique est à ce point efficace qu'elle rend possible, en l'absence de réglementation, l'anéantissement de tout espoir que nos communications restent privées. Une société nous exposant, au gré de l'État, au risque qu'un enregistrement électronique permanent soit fait de nos propos chaque fois que nous ouvrons la bouche, disposerait peut-être d'excellents moyens de combattre le crime, mais serait une société où la notion de vie privée serait vide de sens. Comme le dit le juge Douglas, dissident dans l'affaire United States v. White, précitée, à la p. 756 : [Traduction] « La surveillance électronique est le pire destructeur de la vie privée ». S'il est permis à l'État d'enregistrer et de transmettre arbitrairement nos communications privées, il devient dès lors impossible de trouver un juste équilibre entre le droit du particulier d'être laissé tranquille et le droit de l'État de porter atteinte à la vie privée dans la poursuite de ses objets, notamment la nécessité d'enquêter sur le crime et de le combattre.

Ce n'est pas nier qu'il est d'importance vitale pour les organismes chargés de l'application des lois d'être en mesure de recourir à la surveillance électronique dans leurs enquêtes sur le crime. La surveillance électronique joue un rôle indispensable dans la découverte d'opérations criminelles complexes. Son utilité dans les enquêtes en matière de stupéfiants, par exemple, a été maintes fois confirmée. Mais, pour les raisons déjà évoquées, il est inadmissible dans une société libre que les organes de l'État puissent se servir de cette technologie à leur seule discrétion. Le péril pour la vie privée serait tout à fait inacceptable. »[49]

Comme la surveillance électronique est une ingérence plus large dans la vie privée que les perquisitions ordinaires, la loi prévoit des garanties procédurales plus serrées. Des règles semblables s'appliquent à la surveillance vidéo.

---

[49] R. c. *Duarte*, (1990) 53 C.C.C (3d) 1 (C.S.C.) page 11.

Les décisions que la Cour suprême du Canada a rendues le 25 janvier 1990 dans les affaires *Duarte* et *Wiggins* ont eu un effet important sur les méthodes de maintien de l'ordre, notamment sur les opérations d'infiltration associées aux infractions liées aux drogues et à la moralité. Dans l'affaire *Duarte*[50], la Cour a confirmé que la surveillance électronique constitue une perquisition et saisie au sens de l'article 8. Cela n'est cependant le cas que lorsqu'il existe une attente raisonnable en matière de vie privée. La Cour a déclaré que la surveillance électronique non autorisée et l'interception «*de communications privées, par un organe de l'État, avec le consentement de l'auteur de la communication ou de la personne à laquelle il la destine, sans autorisation judiciaire préalable, constitue[nt] une atteinte aux droits et libertés garantis par l'article 8*». Jusque-là, il était légal pour la police d'intercepter ce genre de communication pourvu que l'une des parties y consente. Il est désormais nécessaire qu'un juge autorise ce genre d'interception de la même façon que l'interception d'une conversation complètement privée (mise sur écoute) lorsqu'aucune des parties n'a donné son consentement préalable. La Cour a également exigé qu'il y ait des motifs raisonnables et probables, faisant l'objet d'une assermentation de l'agent en question, de croire qu'il existe à l'endroit que l'on veut perquisitionner des éléments de preuve d'une infraction. Le soupçon ne suffit pas.

Dans *Duarte*, la Cour suprême du Canada a déclaré que « l'article 8 vise d'abord et avant tout à assurer le respect de la vie privée », qu'elle définit comme étant « *le droit du particulier de déterminer lui-même quand, comment et dans quelle mesure il diffusera des renseignements personnels* ». En conséquence, « on peut difficilement concevoir une activité de l'État qui soit plus dangereuse pour la vie privée des particuliers que la surveillance électronique et qui, en conséquence, doive être plus directement visée par la protection de l'article 8 ». La Cour a estimé qu'elle ne pouvait plus permettre que la police «*à son entière discrétion* [...] *enregistre et transmette nos propos* » sans autorisation judiciaire préalable, parce que cette pratique policière largement répandue représente un « *danger insidieux* » pour « *la marque certaine d'une société libre* », à savoir «*la liberté de ne pas être obligés de partager nos confidences avec autrui*». Dans l'affaire *Wiggins*[51], l'emploi de « micro-émetteurs de poche » par la police a également été jugé contraire à la *Constitution* pour les motifs exposés dans l'affaire *Duarte*. L'arrêt *Duarte* démontre bien que, même si la conduite de la police est autorisée par la loi, cela ne signifie pas qu'elle est raisonnable au regard de l'article 8. Le *Code* a depuis été modifié : il prévoit désormais l'autorisation préalable des interceptions avec consentement.

En ce qui concerne les interceptions clandestines, le juge doit s'assurer 1) que c'est dans l'intérêt de l'administration de la justice et 2) que d'autres procédures d'enquête a) ont été tentées en vain ou b) ne sont pas susceptibles d'être fructueuses ou c) que la situation est urgente. En 2000, dans l'affaire *R. c. Araujo*[52], la Cour suprême du Canada a interprété la deuxième condition énoncée dans la loi. Elle a précisé que la norme,

---

[50] (1990) 53 C.C.C. (3d) 1 (C.S.C.).
[51] [1990] 1 R.C.S. 30.
[52] (2000) C.S.C. 65.

dans le cas du point b), ne relève pas de «l'efficacité », mais de la «nécessité ». Le critère est le suivant : il ne doit pas y avoir, pratiquement parlant, d'autre mode d'enquête valable possible dans les circonstances de ladite enquête judiciaire.

Article 24

Le paragraphe 24(1) de la *Charte* prévoit un recours pour les accusés dont les droits selon la *Charte* ont été enfreints ou violés : ils peuvent s'adresser à un « tribunal compétent » pour obtenir la réparation «convenable et juste ». Le paragraphe 24(2) permet aux tribunaux d'exclure des éléments de preuve obtenus dans des conditions enfreignant ou violant les droits garantis par la *Charte* si leur admission « est susceptible de déconsidérer l'administration de la justice ». Les trois principaux facteurs à prendre en considération sont les suivants : a) « L'admission des éléments de preuve compromet-elle l'équité du procès? b) Quelle est la gravité de l'infraction à la *Charte*? c) Quel serait l'effet de l'exclusion des éléments de preuve sur la réputation du système de justice? ».

Certains critiquent la façon dont ces facteurs sont appliqués aux infractions liées aux drogues. Don Stuart, par exemple, estime ce qui suit :

> « *L'impression que laissent ces récentes décisions de la Cour suprême et de la Cour d'appel de l'Ontario, notamment dans les affaires de drogues, est que ces tribunaux semblent généralement déterminés à ne pas exclure d'éléments de preuve réels obtenus en violation de l'article 8. Ces tribunaux ont tendance à engrener la rhétorique relative au troisième facteur de l'affaire* Collins *au sujet de la gravité du délit et de l'effet de l'exclusion des éléments de preuve fiables sur la réputation du système si cela devait entraîner un non-lieu. S'il s'agit là de la principale raison de l'admission des éléments de preuve, il faut y voir une ironie et une incohérence eu égard à la perspective adoptée dans l'affaire* Stillman, *au sens où la gravité du délit et la fiabilité des éléments de preuve* ne *sont* pas *des facteurs pertinents lorsque les éléments de preuve compromettent l'équité du procès. Au Canada, les procès au criminel en vertu de la* Charte *n'ont plus seulement trait à la détermination de la culpabilité ou de l'innocence de l'accusé, et c'est trahir la* Charte *que de préconiser un retour à la période antérieure à la* Charte, *lorsque la conduite de la police n'était pas un facteur important. La répugnance particulière que l'on éprouve à l'égard des infractions liées aux drogues a bien pu influer sur la réflexion associée au deuxième facteur de l'affaire* Collins, *de sorte que la gravité de l'infraction à la* Charte *est indûment sous-estimée. Les tribunaux, qui sont les gardiens de la* Charte, *doivent se placer au-dessus de la lutte antidrogues. Cette catégorie d'infractions n'exige pas de normes spéciales ou moindres du point de vue de la* Charte. »[53]

La décision d'exclure des éléments de preuve peut être importante ; si les tribunaux hésitent à exclure les éléments de preuve, ils risquent de faire passer un message ambigu : les policiers seront reconnus coupables d'avoir enfreint les droits d'une personne selon la *Charte*, mais ils n'auront guère de raisons de respecter les limites

---

[53] Stuart, D., (1999) «The Unfortunate Dilution of Section 8 Protection», *Queens Law Journal*, volume 25, numéro 1, page 68.

imposées par les tribunaux s'il n'y a pas de conséquences négatives à leur conduite, c'est-à-dire si les éléments de preuve ne sont pas exclus.

La provocation policière et les activités illégales

La provocation policière et les activités illégales de la police relèvent toutes deux de la doctrine de l'abus de procédure.

Provocation policière

Dans certains cas, la police a recours à des indicateurs (y compris des indicateurs rémunérés) ou à des agents d'infiltration pour obtenir de l'information sur les délits. Dans le cas des infractions consensuelles, comme celles qui ont trait aux drogues, l'infiltration d'un groupe et la personnification d'un participant consensuel sont souvent le seul moyen d'obtenir des éléments de preuve. Il s'agit généralement d'observer un suspect et, dans certains cas, de lui donner l'occasion de commettre une infraction. La police doit s'assurer que l'indicateur ou l'agent d'infiltration ne vont pas trop loin. Lorsque les actions de la police sont excessives, l'accusé peut tenter d'invoquer la doctrine de la provocation policière. Les tactiques employées par la police pour donner à quelqu'un l'occasion de commettre une infraction et les activités illégales de la police ne sont pas limitées au domaine des drogues, mais on peut dire que ces tactiques sont plus particulièrement employées dans le cadre des enquêtes sur ce type d'infraction.

La principale décision concernant la provocation policière est l'affaire *R.* c. *Mack* qui a été jugée par la Cour suprême du Canada.[54] Le juge Lamer (selon son titre d'alors) avait rendu le jugement unanime de la Cour suprême du Canada. Il avait expliqué que la provocation policière n'est pas un moyen de défense au fond (comme la nécessité ou la contrainte) et il avait précisé que la logique de ce moyen de défense n'est pas l'absence de culpabilité de l'accusé (puisque les éléments généraux du délit sont généralement présents). Il s'agit plutôt de la nécessité pour la Cour de préserver « l'intégrité de l'administration de la justice » et d'éviter l'abus de procédure judiciaire. La provocation policière relève donc de la doctrine de *common law* de l'abus de procédure. Selon le juge Lamer, il y a provocation policière lorsque la police dépasse les limites acceptables. C'est le cas dans les circonstances suivantes :

- Les autorités fournissent à une personne l'occasion de commettre une infraction sans pouvoir raisonnablement soupçonner que cette personne est déjà engagée dans une activité criminelle, ni se fonder sur une véritable enquête ; ou
- Quoi qu'elles aient ce doute raisonnable ou qu'elles agissent au cours d'une véritable enquête, les autorités font plus que fournir une occasion et incitent à perpétrer une infraction.

---

[54] (1988) 44 C.C.C. (3d) 513 (C.S.C.).

Pour prouver la provocation policière, il suffit à l'accusé de prouver que l'un ou l'autre de ces critères est rempli.

D'après les directives énoncées par la Cour suprême du Canada, les policiers sont tenus de soupçonner raisonnablement que l'accusé est déjà engagé dans des activités criminelles ou doivent agir dans le cadre d'une véritable enquête. L'exigence du soupçon raisonnable a pour raison le « *danger que [la police] n'entraîne des gens qui autrement n'auraient été impliqués dans aucun crime, et [le fait] qu'on ne doit pas avoir recours à la force policière simplement pour éprouver au hasard la vertu des gens* ».[55]

Pour déterminer si la police est allée au-delà d'une offre, le tribunal évaluera la liste non exhaustive de facteurs suivants :

- Le genre de crime qui fait l'objet de l'investigation et la disponibilité d'autres techniques pour la détection par la police de sa perpétration ;
- Si l'individu moyen, avec ses points forts et ses faiblesses, dans la situation de l'inculpé, aurait été incité à commettre un crime ;
- La persistance et le nombre de tentatives faites par la police avant que l'inculpé n'accepte de commettre une infraction ;
- Le genre d'incitations utilisées par la police, y inclus la tromperie, la fraude, la supercherie ou la récompense ;
- Le moment où se situe la démarche de la police, en particulier si la police a déjà fait enquête au sujet de l'infraction ou si elle intervient alors que l'activité criminelle est en cours ;
- Si la démarche de la police présuppose l'exploitation d'émotions humaines, telles la compassion, la sympathie et l'amitié ;
- Si la police paraît avoir exploité une vulnérabilité particulière d'une personne, comme un handicap mental ou l'accoutumance à une substance particulière ;

---

[55] *Ibid.*, page 560.

- La proportionnalité de l'implication de la police, comparée à celle de l'inculpé, y compris une évaluation du degré du dommage causé ou risqué par la police, en comparaison de celui de l'inculpé, et la perpétration de tout acte illégal par les policiers eux-mêmes ;
- L'existence de menaces, tacites ou expresses, proférées envers l'inculpé par la police ou ses agents ;
- Si la conduite de la police cherche à saper d'autres valeurs constitutionnelles.[56]

La Cour suprême du Canada a ajouté que l'allégation de provocation policière est très grave et qu'il convient de laisser à l'État un large pouvoir pour élaborer des techniques propices à la lutte contre la criminalité dans la société. Ce n'est que lorsque la police et ses agents adoptent des comportements contraires aux valeurs fondamentales de la collectivité que la doctrine de la provocation policière doit être invoquée. La Cour a précisé qu'une suspension de l'instance ne doit être décidée que dans « *les cas les plus manifestes* ».[57]

Dans l'affaire *Mack*, la Cour a précisé que, en matière d'infractions liées au trafic de drogues, l'État doit disposer de beaucoup de latitude. Ce type de délit « *ne se prête pas au mécanisme traditionnel d'enquête policière* ». La Cour a ajouté qu'il s'agit d'un « *crime aux conséquences sociales énormes, qui cause un dommage considérable à la société en général » et que « ce facteur, à lui seul, est des plus critiques* ».[58]

La Cour suprême a déclaré dans l'affaire *Mack* que la mise à l'épreuve aléatoire de la vertu des gens n'est pas une chose permise car elle risque d'inciter des innocents à commettre une infraction, mais elle fait une exception à l'exigence du soupçon raisonnable à l'égard de la personne incriminée dans le cas d'une véritable enquête portant sur un secteur où l'on a des motifs raisonnables de soupçonner l'existence d'activités criminelles.

Il est clair que cette exception peut s'appliquer aux lieux connus de trafic de drogues. L'affaire R. c. *Barnes*[59] en est un exemple : le suspect avait été accusé d'un certain nombre d'infractions, dont le trafic de cannabis. Un agent infiltré avait approché l'accusé et son ami parce qu'ils correspondaient généralement au portrait de gens susceptibles de posséder et de vendre de la drogue. Après une brève conversation, l'accusé avait accepté de vendre du hachisch à l'agent infiltré. L'endroit où avait eu lieu l'arrestation (une allée piétonnière de six pâtés de maison) était une zone bien connue de trafic de drogues, et la police y avait effectué ce qu'on appelle des « achats bidons ». Pour se défendre, l'accusé avait invoqué la provocation policière.

La Cour suprême du Canada a rappelé les conditions dans lesquelles il y a provocation policière. Comme, en l'espèce, la police n'avait pas de soupçon

---

[56] *Ibid.*, page 560.
[57] *Ibid.*, page 567.
[58] *Ibid.*, page 69.
[59] (1991) 66 C.C.C. (3d) 1 (C.S.C.).

raisonnable concernant la participation de l'accusé à des activités illicites liées aux drogues, la conduite de la police équivaudrait à de la provocation à moins que son stratagème fasse partie d'une enquête en bonne et due forme. Ainsi, bien que la règle de base veuille que la police n'offre la possibilité de commettre une infraction qu'à un suspect dont elle soupçonne de façon raisonnable qu'il est déjà engagé dans des activités criminelles, il y a exception si cette conduite entre dans le cadre d'une enquête en bonne et due forme portant sur un secteur où l'on a des raisons de soupçonner l'existence d'activités criminelles. Si l'endroit est défini avec « suffisamment de précision », la police peut offrir à n'importe quelle personne associée à ce secteur l'occasion de commettre l'infraction en question. Dans ce cas, la conduite de la police ne serait pas considérée comme une mise à l'épreuve aléatoire de la vertu des gens.

En résumé, les principaux enjeux de la provocation policière sont les suivants : la police avait-elle des motifs ou des soupçons valables justifiant sa décision de viser tel suspect ou agissait-elle dans le cadre d'une enquête en bonne et due forme? De plus, même si le premier critère est rempli, il faut se demander si la police a fait plus qu'offrir une occasion en déterminant si les tactiques employées auraient incité une personne ordinaire à commettre une infraction. Rappelons, cependant, que, en ce qui a trait à la provocation policière, [Traduction] « *les situations factuelles peuvent varier énormément, et c'est pourquoi, bien que des principes généraux commencent à émerger, leur application n'est pas toujours évidente et risque de donner lieu à des désaccords* ».[60] Les tribunaux estiment que chaque cas doit être évalué isolément, ce qui complique la tâche de fournir des règles plus précises au sujet de la conduite de la police.

Activités illégales

Comme nous l'avons vu, à mesure que les contrevenants deviennent plus subtils, la police adopte de nouveaux instruments d'enquête pour tenter de suivre cette évolution (y compris les cas où des policiers enfreignent la loi dans l'exercice de leurs fonctions). C'est le cas, par exemple, dans les enquêtes relatives aux drogues, lorsque la police se livre à des activités comme les opérations «d'achat bidon » et les opérations de vente surveillée par l'intermédiaire d'agents d'infiltration. Le recours à des activités policières illégales pour lutter contre le crime soulève la question de savoir si ce genre de conduite donne lieu à un abus de procédure tel qu'un sursis de l'instance sera accordé. La Cour suprême du Canada a déclaré que les activités policières illégales ne représentent pas nécessairement un abus de procédure. La légalité des actions de la police n'est qu'un des facteurs à envisager, «*quoiqu'[il soit] important* ». La question des activités policières illégales est importante, mais elle a moins d'importance dans le cas de l'application de la loi en matière de drogues. La raison en est que la loi en matière de

[60] Mewett, A.W . et S. Nakatsuru, (2000) *An Introduction to the Criminal Process in Canada*, 4e édition, Carswell, page 180.

drogues prévoit l'immunité des policiers pour des activités comme les opérations « d'achat bidon » et les opérations de vente surveillée par un agent d'infiltration.[61]

La principale cause relative aux activités illégales de la police est l'affaire R. c. *Campbell*.[62] La police avait procédé en l'espèce à une vente surveillée par l'intermédiaire d'agents infiltrés se faisant passer pour des distributeurs de grande envergure. Les accusés avaient fait valoir que la conduite de la police était illégale puisqu'elle s'était engagée elle-même dans le trafic de drogues (la LRDS et l'exemption qu'elle prévoit n'avaient pas encore été adoptées). Ils avaient ajouté que cela constituait un abus de procédure.

Selon la Cour suprême du Canada, la police n'était pas exempte de responsabilité pénale relativement aux actes commis dans le cadre d'une enquête, à moins que la loi l'y autorise. La Cour a ajouté que la question devait être confiée au Parlement : « *S'il y a lieu de conférer à la police une certaine forme d'immunité d'intérêt public pour l'aider dans la "guerre contre la drogue", il revient au Parlement de circonscrire la nature et la portée de l'immunité ainsi que les faits qui y donnent ouverture* ».[63] Lorsque des activités illégales présumées de la police sont autorisées par le système législatif, il n'y a pas abus de procédure. La Cour suprême du Canada a ajouté cependant que les activités illégales de la police ne constituent pas automatiquement un abus de procédure. La légalité des actions de la police n'est que l'un des facteurs à envisager, « quoiqu'[il soit] important ».

Cette décision pourrait avoir un effet important sur le mode d'exécution général de la loi au Canada, mais ses répercussions sont moins importantes dans le cas de l'exécution de la loi en matière de drogues. En effet, l'on a modifié la loi pour permettre aux policiers de s'engager dans des activités similaires à celles de l'affaire *Campbell*.

La LRDS proscrit diverses activités telles que la possession, le trafic et la fabrication de drogues, tout en prévoyant certaines exemptions réglementaires, par exemple l'importation par des revendeurs autorisés et la vente par des pharmaciens. La *Loi* prévoit également la possibilité de passer des règlements ayant trait à l'exécution, par exemple en ce qui concerne l'exemption des policiers de l'application de la *Loi* dans certaines circonstances précisées dans la réglementation. Elle prévoit également la possibilité de passer des règlements « relativement aux enquêtes et autres activités policières menées aux termes de la présente loi par les membres d'un corps policier et toutes autres personnes agissant sous leur autorité et leur supervision ». La réglementation prévoit donc un cadre juridique pour les techniques spécialisées d'exécution de la loi (notamment en ce qui a trait aux opérations « d'achat bidon » et aux opérations de vente surveillée par l'intermédiaire d'agents d'infiltration) et elle énonce les paramètres applicables à ce genre d'activités. La police s'appuie sur cette réglementation pour se protéger contre les poursuites.

---

[61] Les activités illégales entreprises par des agents de police soulèvent aussi la question de savoir si ces derniers s'exposent à des poursuites. Cette question échappe à la portée du présent document.

[62] (1999) 133 C.C.C. (3d) 257 (C.S.C.).

[63] *Ibid.*, page 282.

L'article 3 du *Règlement sur les stupéfiants* autorise les policiers à posséder des narcotiques lorsque « cette possession a trait à leurs fonctions et à leurs objectifs ». De plus, le *Règlement sur l'exécution policière de la LRDS* exempte les policiers des infractions de trafic, d'importation, d'exportation et de production de drogues et énonce les conditions d'admissibilité à cette exemption. Des règles différentes s'appliquent selon la source des drogues. Mais l'intéressé doit en tout temps être un membre actif de la police et il doit se trouver dans l'exercice de ses fonctions dans le cadre de l'enquête en question.

La LRDS accorde donc une immunité spéciale aux agents de police. La législation pénale canadienne a été modifiée récemment afin que les policiers jouissent d'une exemption *générale* en matière de responsabilité criminelle. Elle accorde aux personnes chargées de l'application de la loi et celles qui agissent sous leur direction et leur autorité (« agents de police ») une immunité limitée en matière pénale pour certains actes, commis durant une enquête en bonne et due forme, qui constitueraient par ailleurs une infraction, si certaines conditions sont remplies.[64]

Conclusion

Le Parlement et les tribunaux comprennent manifestement que, à mesure que les criminels deviennent plus subtils, la police doit disposer de moyens plus perfectionnés pour lutter contre eux. En outre, il est clair que les tribunaux considèrent le commerce des drogues illicites comme un problème grave. Ils font souvent état, dans leurs décisions, du caractère sinistre de ce commerce et de ses effets sur la société. Ils peuvent être influencés par ces considérations lorsqu'ils doivent déterminer les limites de la conduite de la police. Ils sont conscients de la difficulté du travail des policiers et sont souvent disposés à leur accorder une « latitude considérable ». En voici un exemple dans une déclaration de la Cour suprême du Canada concernant la vente de drogues : « *C'est un crime qui a des conséquences dévastatrices pour les individus et la société. De plus, il s'accompagne souvent et tragiquement de l'usage d'armes à feu. Ce crime est un fléau social et aucun effort ne doit être ménagé pour l'enrayer* ».[65] Et voici ce qu'elle a déclaré dans une autre cause : « [...] *notre Cour doit également tenir compte du droit de la société en matière d'application de la loi, notamment dans le domaine du commerce illégal de la drogue. Ce fléau endémique dans notre société permet à des criminels hautement perfectionnés de tirer avantage de la souffrance qu'ils infligent à d'autres* ».[66] Cependant, la police n'a pas « carte blanche » pour faire ce qu'elle veut en vue de régler une affaire criminelle. On doit continuer d'examiner attentivement les activités de la police afin de s'assurer que sa conduite ne choque pas la collectivité et ne compromet en rien l'équité du procès des accusés.

---

[64] SC 2001, chapitre 32.

[65] R. c. *Silveira*, (1995) 97 C.C.C. (3d) 450, page 496.

[66] R. c. *Grant*, (1993) 84 C.C.C. (7d) 173.

STATISTIQUES

Les données qui suivent sur les statistiques criminelles en rapport avec la mise en application des lois relatives aux drogues illicites doivent être interprétées avec prudence. Il est généralement admis que les statistiques sur la criminalité compilées par la police reflètent davantage les activités policières que l'évolution réelle de la société, tout particulièrement dans le cas des infractions de type consensuel. De surcroît, comme en d'autres domaines en matière de drogues et plus largement en matière de justice pénale, les statistiques canadiennes sont relativement déficientes – ainsi, au delà de quelques données de base, il est à peu près impossible de connaître les caractéristiques des personnes qui se retrouvent dans le système de justice criminelle.

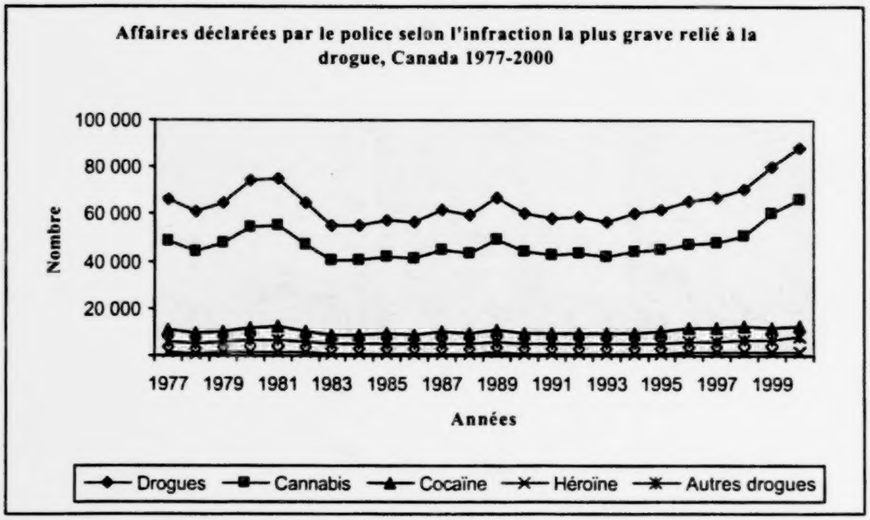
Incidents relatés[67]

Ces statistiques portent sur les incidents qui sont venus à l'attention de la police et qui ont été saisis et transmis au Centre canadien de la statistique juridique en vertu d'un ensemble de catégories criminelles et de définitions approuvées à l'échelon national. Le nombre réel d'infractions relatives aux drogues serait bien plus élevé, puisqu'on peut supposer que la plupart des infractions de ce genre échappent à l'attention de la police. Comme c'est le cas des autres infractions de type consensuel, il est impossible de déterminer avec précision le volume d'activités illégales. De plus, la comptabilité annuelle ne tient compte que des infractions les plus graves commises lors de chaque incident criminel, ce qui mène par conséquent à une sous-estimation du nombre total d'incidents criminels en rapport avec la drogue, en particulier des infractions impliquant des pénalités moins graves. Il ne faut pas non plus confondre le nombre d'incidents relatés avec le nombre d'accusations portées par la police. Puisque la police jouit d'une grande discrétion lorsque vient le temps de porter ou non une accusation, il est clair que le nombre d'accusations sera largement inférieur au nombre total d'incidents rapportés.

Le graphique suivant rapporte les données sur le nombre d'incidents signalés par la police en fonction des crimes les plus graves. Il démontre que de 1983 à 1995, le nombre d'infractions relatives aux drogues était relativement stable, oscillant autour de 60 000 par année. Cependant, de 1995 à 2000, il y a eu une augmentation d'environ 50 %, le nombre d'incidents rapportés atteignant presque 88 000. En 2001, ce nombre a atteint 91 920, soit une augmentation de 3,3 % par rapport à l'année précédente.

---

[67] Le Centre canadien de la statistique juridique nous met en garde à l'effet que les statistiques sur le crime peuvent être influencées par de nombreux facteurs tels les rapports présentés à la police par le public, les rapports de la police au Centre canadien de la statistique juridique; l'impact des nouvelles initiatives comme les changements au niveau des lois, de la police ou des pratiques de mise en application; ainsi que les changements sociaux, économiques et démographiques.



L'augmentation constatée au cours des dernières années peut être largement imputée aux infractions relatives au cannabis – en 2001, on a constaté une augmentation de 5,5 % par rapport à l'année précédente. Ces infractions constituent la majorité de toutes les infractions relatives aux drogues au Canada. En 2001, on a relaté 71 624 infractions concernant le cannabis, **soit presque 77 % de tous les incidents en rapport avec les drogues.** De ce nombre, 70 % concernaient la possession, 16 % le trafic, 13 % la culture et 1 % l'importation.[68] Autrement dit, **environ 54 % de tous les incidents rapportés en rapport avec des infractions touchant la drogue concernaient la possession de cannabis.** Ramenés sur une base du nombre d'infractions par 100 000 de population, on voit mieux l'évolution et le poids du cannabis :

Infractions sélectionnées relatives aux drogues, taux par 100 000, Canada 1994-2001

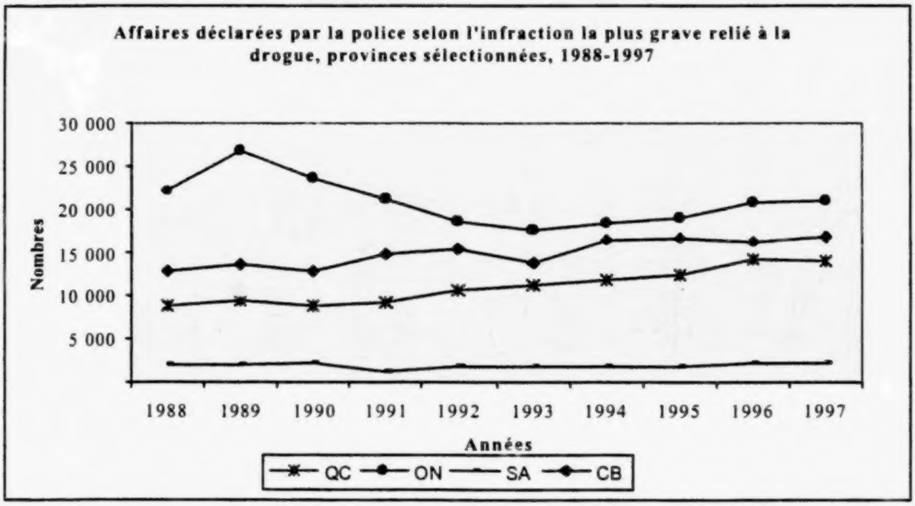
	1994	1995	1996	1997	1998	1999	2000	2001
Cannabis	138	148	157	160	168	197	215	227,2
dont possession	97	103	110	108	115	130	147	
Cocaïne	42	38	37	38	40	39	42	39,4
Total toutes drogues	207	208	217	222	235	263	286	295,7

[68] Statistiques Canada, Centre canadien de la statistique juridique, *Juristat*, Statistiques criminelles au Canada - 2001, catalogue no 85-002-XIE Vol. 22, no 6, page 11.

De 1991 à 2001, le taux d'infractions relatives au cannabis par 100 000 habitants a augmenté de 91,5 %, tandis qu'il diminuait de 31,5 % pour les infractions relatives à la cocaïne, de 36,1 % pour les infractions relatives à l'héroïne, et augmentait de 15,0 % dans le cas des autres drogues. **Autrement dit, proportionnellement à la population, le nombre d'infractions relatives au cannabis a presque doublé au cours de la dernière décennie.**

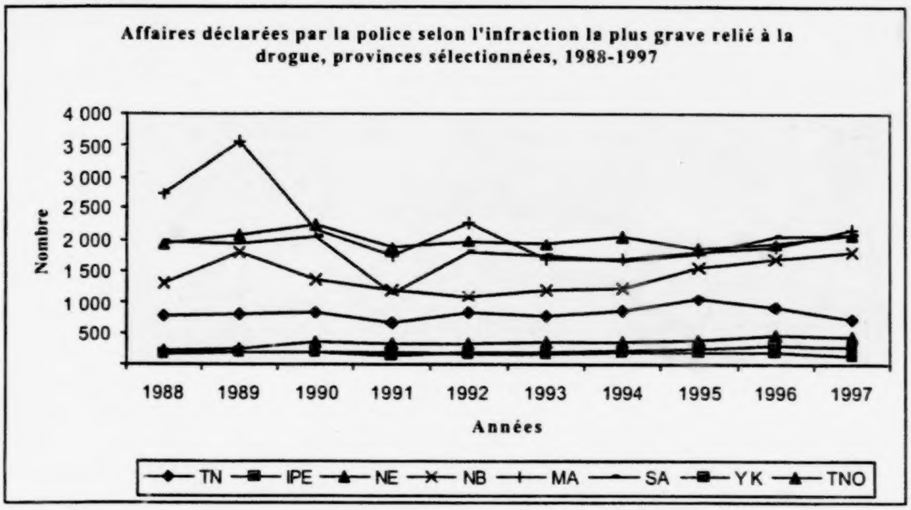
Au cours des dernières années, la culture du cannabis, tout particulièrement en Colombie-Britannique, a soulevé de nombreuses inquiétudes. Ce type d'infraction a également connu une augmentation importante au cours de la dernière décennie, passant de 7 incidents par 100 000 habitants en 1990 à 29 en 2001.[69] Selon une étude récente, le nombre de cas de culture illicite de cannabis en Colombie-Britannique augmente en moyenne de 36 % par année, et la taille des cultures augmente en moyenne de 40 % par année. Selon cette étude, la grande majorité des cas portés à l'attention de la police en Colombie-Britannique le sont à la suite de plaintes du public, ce qui signifie que l'augmentation du nombre de cas ne résulte pas d'une exécution proactive accrue des lois par la police.[70]

Les deux graphiques suivants portent sur la répartition des incidents selon les provinces de 1988 à 1997. Il n'est pas surprenant de constater que les provinces les plus populeuses viennent au premier rang, soit l'Ontario suivi de la Colombie-Britannique, du Québec et de l'Alberta.



[69] *Ibid.*

[70] Plecas, D., et coll., (2002) *Marihuana Growing Operations in British Columbia – An Empirical Survey (1997-2000)*, département de criminologie et de justice criminelle – University College of the Fraser Valley et International Centre for Criminal Law Reform and Criminal Justice Policy.



Les taux calculés sur la base d'une population de 100 000 habitants révèlent mieux les tendances. La Colombie-Britannique a toujours présenté le taux provincial le plus élevé au pays pour les crimes attribuables à la drogue.[71] Ainsi, en 2000 le taux était de 563,5 incidents par 100 000, soit presque le double de la moyenne nationale à 295,7. Les taux dans les autres provinces sont les suivants : Terre-Neuve et Labrador (173,1), Île du Prince-Édouard (192), Nouvelle-Écosse (218,3), Nouveau-Brunswick (346,9), Quebec (262,1), Ontario (256,1), Manitoba (215,9), Saskatchewan (278,4), Alberta (235,3), Yukon (478,5), Territoires du Nord-Ouest (597,2) et Nunavut (806,1). On constate que le taux de délits reliés aux drogues varie énormément entre les provinces et territoires.

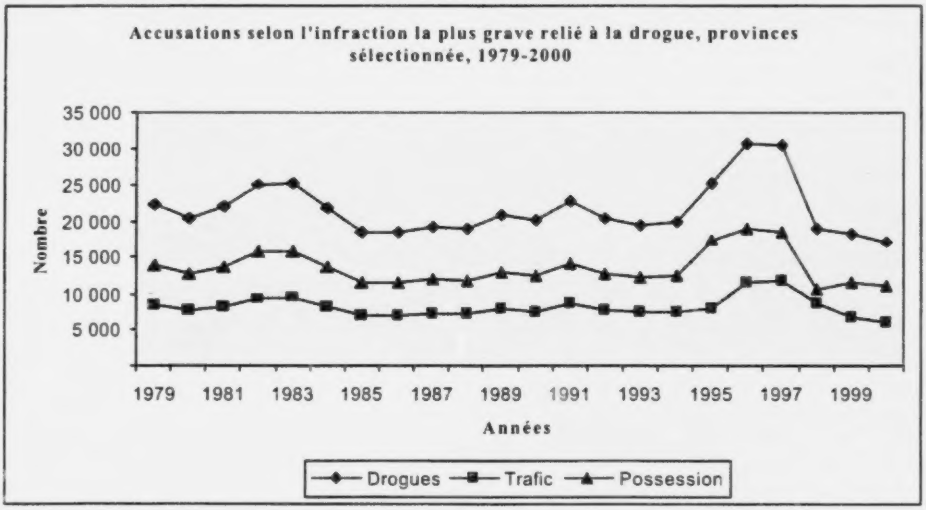
Accusations

Rappelons que le nombre d'incidents rapportés n'équivaut pas au nombre d'accusations portées par la police. Dans certains cas, la police informera Statistiques Canada d'un incident lié à la drogue, mais on décidera de ne pas accuser le contrevenant. Cette discrétion absolue dont jouit la police peut susciter de sérieuses inquiétudes en matière d'application de la loi ; il en sera question plus loin dans ce chapitre.

Comme le démontre le graphique suivant, les données disponibles semblent indiquer que le nombre d'accusations de trafic et de possession pour infractions en matière de drogues a diminué grandement depuis 1997. Toutefois, nous ne disposions

[71] On devrait préciser qu'en 1997, le taux au Yukon et dans les Territoires du Nord-Ouest était même plus élevé qu'en Colombie-Britannique.

d'aucune donnée pour trois provinces (le Nouveau-Brunswick, le Manitoba et la Colombie-Britannique), ainsi qu'un territoire (Nunavut). De plus, les données de certains tribunaux québécois n'y sont pas incluses.[72]



Puisque qu'on ne tient pas compte de trois provinces – en particulier de la Colombie-Britannique – le nombre réel d'inculpations attribuables à la drogue au Canada est sûrement plus élevé, d'autant plus que la Colombie-Britannique a constamment présenté le taux de criminalité le plus élevé en matière de drogues.

Cependant, les statistiques de 1997 démontrent que lorsqu'il s'agit d'accuser les auteurs d'infractions liées aux drogues, la Colombie-Britannique est plus indulgente que les autres provinces.

> *« Parmi les provinces et les territoires, les services de police de la Colombie-Britannique ont présenté le plus faible taux d'accusation (47 %) pour des infractions liées aux drogues. Seulement 35 % des incidents en rapport avec le cannabis et 36 % des incidents concernant « d'autres drogues » ont mené à des accusations, comparativement à 79 % et 81 % dans toutes les autres provinces combinées. »*[73]

Le surintendant Ward Clapham de la GRC à Richmond nous a déclaré que pour les délits de possession de moins de 30 grammes de marijuana, on n'a accusé que 40 personnes sur 700 cas rapportés en 2000, alors qu'à peine 30 personnes sur 605 ont

---

[72] De plus, les données d'avant 1995 reposent sur des approximations basées sur une répartition moyenne des accusations au cours de la période couvrant les années 1995 à 2000.

[73] Statistiques Canada, Centre canadien de la statistique juridique, *Juristat*, Drogues illicites et criminalité au Canada, catalogue no 85-002-XIE, vol. 19, no 1, p. 5. Le terme « autres drogues » signifie ici : 1) les drogues illégales autres que le cannabis, la cocaïne ou l'héroïne, et 2) les drogues contrôlées.

été accusées en 2001. Soulignons à nouveau la disparité de l'application de la loi entre les diverses régions du pays.

En matière d'infractions liées au cannabis en 2001, les hommes sont plus susceptibles de faire l'objet d'une accusation. Chez les jeunes (12 à 17 ans) et les adultes, 88 % des personnes inculpées pour des infractions liées au cannabis sont des hommes.[74] Les jeunes comptent pour 18 % des accusations portées en rapport avec le cannabis.[75]

Alors que le graphique ci-dessus semble démontrer qu'on dénombre moins de 20 000 accusations attribuables aux drogues en 1999, le rapport 2001 de la vérificatrice générale indique qu'au cours de cette année, on a accusé tout près de 50 000 personnes pour des infractions liées à la drogue en vertu de la LRDS (dans les cas où les infractions les plus graves étaient liées à la drogue). C'est là l'une des conséquences de l'enregistrement des statistiques en fonction des infractions les plus graves puisque cette méthode omet de nombreuses infractions, en particulier celles qui s'accompagnent de pénalités moins graves. Dans la hiérarchie des 152 infractions criminelles, les délits relatifs au cannabis sont en effet plutôt mineurs : l'importation ou l'exportation est au 44e rang, le trafic de plus de 3000 grammes au 46e, la production au 52e, la trafic de moins de 3 000 grammes au 120e et la possession de 30 grammes ou moins au 121e.

Sur les 50 000 accusations portées en 1999 en matière de drogues, le cannabis était impliqué dans 70 % des cas. **Dans 43 % des cas liés aux drogues (21 381), l'accusation concernait la possession de cannabis.** Globalement, 54 % des infractions liées aux drogues touchaient la possession. Puisque le nombre d'incidents relatés a continué d'augmenter, on peut supposer qu'un plus grand nombre de personnes sont accusées d'infractions liées à la drogue, en particulier au cannabis.

Avec plus de 34 000 accusations par année pour des infractions liées au cannabis et plus de 21 000 accusations par année pour possession de cannabis, peut-on déduire que la police fait effectivement la chasse aux infractions pour possession de cette substance ? Après avoir examiné la preuve, nous ne croyons pas qu'il en soit ainsi. Néanmoins, plus de 21 000 nouvelles personnes, dont l'infraction la plus grave était la possession de cannabis, se retrouvent chaque dans les filets du système de justice pénale. Répétons que ces statistiques reposent sur l'infraction la plus grave enregistrée lors d'un incident donné.

On nous a offert plusieurs raisons pour justifier le nombre élevé d'infractions liées à la possession. Les personnes chargées de mettre en application la LRDS nous ont répété à plusieurs reprises qu'elles ne cherchent pas activement ces infractions mais les trouvent dans le cours normal de leurs opérations. Malgré que nous ne doutions pas de la véracité de ces déclarations, on peut dans certains cas – comme on le verra plus loin – remettre en question les tactiques policières. On nous a aussi dit que l'infraction de

---

[74] Statistiques Canada, Centre canadien de la statistique juridique, Juristat, Statistiques de la criminalité au Canada - 2001, catalogue no 85-002-XIE, vol. 22, no 6, page 19.
[75] *Ibid.*

trafic, lorsqu'elle s'étend sur une certaine période, est considérée comme une seule infraction selon la règle de l'infraction continue. Les infractions pour possession, par contre, ne fonctionnent pas de cette façon.

Inquiétudes

Alors qu'il peut exister des raisons valides à l'incidence élevée des accusations pour possession, plusieurs se sont dits très inquiets du pouvoir discrétionnaire dont disposent les corps policiers dans les cas d'accusations de possession liées à la drogue – surtout dans les cas de possession de cannabis. Comme nous l'avons mentionné précédemment, le nombre d'accidents rapportés et le taux d'accusation varient grandement d'une province à l'autre. Cette application non uniforme de la loi sur les drogues dans les différentes provinces et au sein d'une même province nous inquiète.

Ainsi, M. Kash Heed du service de police de Vancouver, rapportait au Comité que la possession à faible échelle de quelque drogue que ce soit à Vancouver ne fait pratiquement l'objet d'aucune accusation de la part de la police à moins de circonstances aggravantes. Le service de police préfère concentrer ses efforts sur ceux qui en profitent, soit les trafiquants et les producteurs. Il ajoutait, ce que les données tendent à confirmer, que le nombre de poursuites pour possession de cannabis en Colombie-Britannique est relativement peu élevé comparativement aux autres provinces, et que des différences importantes existent à l'intérieur de la Colombie-Britannique – les centres situés à l'extérieur de Vancouver présentant des taux plus élevés de poursuites pour possession de cannabis. Il concluait en disant que la prohibition totale avait «entraîné une augmentation des coûts d'application de la loi, l'aliénation de certains groupes de personnes, une mise en application discriminatoire, sans pour autant dissuader la vente et moins encore l'utilisation ».

Nous avons estimé que près de 2,5 millions de personnes au Canada ont consommé du cannabis au cours de la dernière année. En 2000, 21 381 personnes ont été accusées de possession de cannabis. Autrement dit, à peine 0,8 % des usagers ont été accusés de possession. Il est également important de se rappeler que parmi les personnes ayant consommé du cannabis au cours de la dernière année, plusieurs l'auraient fait plus d'une fois. Ainsi, le risque réel de se voir accusé de possession de cannabis est selon toute probabilité inférieur à 1 %. Cela soulève certainement des inquiétudes sur le plan de l'équité et remet sérieusement en question l'efficacité de la loi et son effet dissuasif.

Quelles sont les conséquences éventuelles d'une application non uniforme de la loi et d'un pouvoir discrétionnaire absolu dans la décision de porter ou non une accusation ? Marie-Andrée Bertrand, faisant référence à une étude réalisée par Nicolas Carrier[76] a déclaré ce qui suit :

---

[76] Carrier, N. (2000) *Discours de patrouilleurs montréalais sur la détection de l'infraction de possession de drogues prohibées.* Mémoire de maîtrise. École de criminologie, Université de Montréal. Voir aussi le témoignage de Marie-Andrée Bertrand,

« Dans une étude qualitative récente des membres du service de police de la Communauté urbaine de Montréal, on souligne l'ambivalence et la confusion régnant chez les agents de police de première ligne et leurs réactions variées face au « problème des drogues ». On perçoit l'ampleur du problème de façon passablement différente, tout dépendant des agents et des voisinages qu'ils patrouillent. Dans l'esprit de certains, tout particulièrement des jeunes consommateurs de drogues et des « échangeurs », malgré que « la loi soit la loi » et qu'on doit sans aucun doute la mettre en application, la possession et la consommation de drogues n'inquiètent pas vraiment la police. Il est tout simplement impossible d'instaurer la prohibition. Il est impossible de déterminer les cas de possession en l'absence de pouvoirs permettant la fouille et la saisie, sauf « en masse » ou lorsqu'on arrête des personnes soupçonnées d'autres « crimes ». Lorsqu'on découvre les cas de possession et les transactions de drogues sur la place publique, soit par accident ou lorsqu'on enquête sur d'autres infractions, les agents de police réagissent de façons variées, tout dépendant de leurs aspirations professionnelles. Les agents en quête de promotion et d'une spécialisation (qui souhaitent accéder aux escouades antidrogues ou des crimes sans victime) refilent les renseignements aux divisions concernées. Les patrouilleurs qui souhaitent le demeurer ferment les yeux ou questionnent les suspects afin d'obtenir des renseignements sur leurs opérations de trafic en échange de promesses d'immunité, ou ils confient ces personnes qui abusent des substances aux services de traitement, appellent les parents d'un mineur, etc. » [77]

L'application non uniforme de la loi constitue une de nos principales inquiétudes, et ce, pour diverses raisons. Premièrement, cela entraîne une application discriminatoire, puisque certaines personnes sont plus susceptibles d'être accusées que d'autres en raison de leurs caractéristiques personnelles. Alors que les statistiques nationales actuelles ne permettent pas une telle analyse, on dispose de données à l'effet que la loi fait l'objet d'une exécution discriminatoire.

L'étude de Carrier mentionnée ci-dessus, basée sur des entrevues menées auprès de 21 patrouilleurs de la région montréalaise, aborde les difficultés de détecter les cas de possession en raison de l'absence de « victime », du caractère discret des infractions et des limites constitutionnelles au niveau des fouilles sans mandat. Elle montre que les décisions d'un agent de police dépendent de nombreux facteurs, notamment la manière dont l'agent perçoit le problème des drogues ainsi que ses aspirations professionnelles, celui qui souhaite obtenir une promotion agissant de façon davantage proactive aux infractions liées à la drogue que ceux qui se contentent d'un poste de patrouilleur et qui adoptent, par conséquent, un caractère plus réactif.

Comment procède-t-on pour détecter les infractions de possession ? Les agents ont indiqué qu'on détecte la plupart des infractions lorsqu'on arrête une personne pour une autre activité criminelle, puisque cette arrestation permet à un agent de procéder à une fouille sur la personne. En de rares occasions, les agents ont détecté l'infraction alors que la personne faisait ouvertement fi de la loi.

---

[77] Voir aussi la discussion qu'en fait M. Guy Ati-Dion lors de son témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 29 octobre 2001, fascicule 8, pages 73-74.

Précisons cependant que les agents ont également ajouté que certaines personnes attiraient leur attention et que la présence de certains « signes » les portaient à croire que ces personnes étaient en possession de substances illégales. Lorsque les personnes sont dans une automobile on a mentionné les facteurs suivants : l'apparence des passagers dans le véhicule ; le modèle et la valeur du véhicule ; les habitudes de conduite de la personne ; et une vérification informatique de la plaque d'immatriculation, révélant si la personne était fichée ou non. Les agents peuvent aussi arrêter des personnes pour vérification de documents (p. ex., permis de conduire) ce qui peut mener à détecter la présence de stupéfiants s'il y a fouille. En ce qui a trait aux piétons, les policiers faisaient état des facteurs suivants : la personne est un usager connu ; l'apparence physique de la personne ; ses activités ; ses relations avec d'autres « suspects » ; et sa relation avec des lieux qu'on soupçonne de servir au trafic. Certains agents ont précisé qu'un interrogatoire de ces suspects peut mener à une arrestation – par exemple, en réalisant qu'un mandat d'arrestation n'a pas été exécuté – et à une fouille. Les agents ont également précisé qu'ils ont occasionnellement appliqué les règlements municipaux et autres lois provinciales dans le but de connaître le nom d'une personne pour ensuite procéder à une enquête sur cette dernière. Si une personne refuse de dévoiler son nom, on peut l'arrêter et la fouiller. Les agents ont de plus indiqué avoir fait appel à certaines techniques pour « aller à la pêche ». Alors que la preuve n'était pas admissible en cour, elle permettait dans certains cas à l'agent d'obtenir des renseignements de cette personne en échange de la promesse «de ne pas porter d'accusations » ou bien, elle permettait à l'agent de saisir la substance illégale.

Malgré la portée limitée de cette étude, elle indique à quel point la discrétion dans la façon dont les forces policières exécutent les lois antidrogues peut mener à la discrimination selon des facteurs comme l'apparence d'une personne.

Une autre inquiétude que soulève pour nous l'application inégale de la loi tient au risque d'aliéner certains groupes de la société. Les personnes ainsi touchées peuvent cesser de respecter la police et le système de justice criminelle en général. Il est probable que des solutions juridiques contradictoires suscitent une atmosphère jetant le discrédit sur l'administration de la justice. Comme parlementaires, nous considérons cela inacceptable.

Enfin, soulignons la question fondamentale d'équité et de justice. Personne ne semble être en mesure d'expliquer la raison pour laquelle certains se voient accusés et d'autres non. Il n'est pas surprenant que cette loi fasse l'objet d'une critique si véhémente.

La Loi sur les douanes - amendes

Lorsqu'il est question de l'application des lois antidrogues, on pense généralement aux accusations déposées et aux saisies effectuées par la police en vertu de la LRDS. Cependant, dans certaines circonstances, ce sont d'autres lois qui s'appliquent. Par exemple, la *Loi sur les douanes* permet la saisie de marchandises prohibées et de véhicules

utilisés en violation de cette loi. Dans ces cas, une pénalité de nature civile peut être imposée à l'importateur dans la mesure où, pour reprendre possession de son véhicule, la personne doit verser une amende. Le montant de la pénalité est fonction de la quantité de drogues comme le montre le tableau suivant.

Quantité	Marijuana	Haschich	Huile	Drogues contrôlées	Hallucinogènes	Cocaïne Opiacés
220 $	8 à 15 grammes	2 à 4 grammes	Moins d'un gramme	De 10 à 20 comprimés	Entre 1 et 4 doses	1 gramme ou moins de 400 $
440 $	Entre 15 et 30 grammes	Entre 4 et 8 grammes	Entre 1 et 2 grammes	De 20 à 40 comprimés	Entre 4 et 8 doses	
550 $	Entre 30 et 60 grammes	Entre 8 et 16 grammes	Entre 2 et 4 grammes	De 40 à 60 comprimés	Entre 8 et 12 doses	
660 $	Entre 60 et 100 grammes	Entre 16 et 24 grammes	Entre 4 et 6 grammes	De 60 à 80 comprimés	Entre 12 et 16 doses	
770 $	Entre 100 et 150 grammes	Entre 24 et 32 grammes	Entre 6 et 8 grammes	De 80 à 110 comprimés	Entre 16 et 20 doses	
880 $	Entre 150 et 200 grammes	Entre 32 et 40 grammes	Entre 8 et 10 grammes	De 100 à 140 comprimés	Entre 20 et 24 doses	
990 $	Entre 200 et 250 grammes	Entre 40 et 46 grammes	Entre 10 et 12 grammes	De 140 à 160 comprimés	Entre 24 et 28 doses	
1100 $	Entre 250 et 300 grammes	Entre 46 et 56 grammes	Entre 12 et 14 grammes	Dde 160 à 180 comprimés	Entre 28 et 32 doses	

Pour les quantités excédant les quantités prévues ci-dessus :

Pus de 300 grammes: 4 $ pour chaque gramme additionnel	Plus de 56 grammes : 20 $ pour chaque gramme additionnel	Plus de 14 grammes : 70 $ pour chaque gramme additionnel	Plus de 180 comprimés : 8 $ pour chaque comprimé additionnel	Plus de 32 doses : 40 $ pour chaque dose additionnelle	Plus de 1 gramme : 400 $: $pour chaque gramme

L'ADRC procédera aussi à l'arrestation de l'importateur, en vertu de la *Loi sur les douanes,* pour importation illégale de substances qui sont interdites, restreintes ou contrôlées en vertu de la Loi ou de toute autre loi du parlement, notamment la LRDS. Une fois la saisie et l'arrestation faites, l'agent des douanes informe la police locale qui décidera si des accusations criminelles seront portées ou non. Dans certains cas, l'ADRC a une entente de poursuite avec la force locale de police. La Couronne décidera ensuite s'il y a lieu d'intenter des poursuites, selon la nature du cas.

Selon l'article 6 de la LRDS, l'importation de drogues, sauf lorsque les règlements l'autorisent, est une infraction quelle que soit la quantité. Dans ces cas, il n'y a donc pas de seuil de quantité sous lequel une sanction moins élevée ou une amende peut être imposée. Toutefois, si la quantité importée est considérée pour usage personnel et non pour la revente, la Couronne peut choisir de poursuivre pour possession plutôt que pour importation.

L'ADRC à Windsor est liée à la GRC de Windsor par une entente qui définit les directives régissant la décision de poursuite au criminel dans les cas de saisies de drogues réalisées aux frontières. Les quantités indiquées ne sont que des guides, mais

de façon générale la GRC n'accusera pas une personne d'importation pour une quantité inférieure à 50 grammes de marijuana, 20 grammes de hachisch ou 15 grammes d'huile de hachisch. Dans ces cas, on procède en vertu de la *Loi sur les douanes*. De 1996 à 2001, presque 99 % des 4 055 saisies de marijuana portaient sur des quantités inférieures à 50 grammes.

SAISIES

Le tableau suivant porte sur les saisies effectuées par la GRC, l'ADRC, la Sûreté du Québec, la police provinciale de l'Ontario et les forces de police municipales à Montréal, Laval et Toronto sur la période 1993-2001.

Drogues saisies au Canada - 1993 – 2001

	1993	1994	1995	1996	1997	1998	1999	2000	2001
Héroïne	153	85	128	83	95	105	88	168	74
Cocaïne	2,731	7,915	1,544	3,110	2,090	2,604	1,116	1,851	1,783
Ecstasy (unités)				1,221	10,222	68,496	400,000	2,069,709	1,871,627
Marijuana (kg)	7,314	6,472	5,500	17,234	50,624	29,598	23,829	21,703	28,746
Marijuana (plantes)	238,601	288,578	295,999	675,863	689,239	1,025,808	954,781	1,102,198	1,367,321
Haschich (kg)	56,721	36,614	21,504	25,155	6,118	15,924	6,477	21,973	6,677
Haschich liquide	669	659	663	805	824	852	434	1,240	397

(Le poids est exprimé en kilos; en doses pour l'ecstasy.)

Selon Steve Pudney, professeur au Centre de recherche économique de la Leicester University, « les données sur la saisie constituent l'information la plus directe sur la disponibilité des drogues, et ce, même si les drogues saisies ne contribuent pas aux quantités disponibles ».[78] Toutefois, les tendances au niveau des saisies de drogues réalisées par la GRC, démontrent qu'on doit utiliser ces données avec prudence, le nombre d'interceptions ou les quantités saisies au cours d'une année n'étant pas

[78] Annexe B. 'Commentaires du lecteur externe.' In Bramley-Harker (2001) *Sizing the UK market for illicit drugs.* London: Home Office. RDS Occasional Paper no 74.

nécessairement un indicateur fiable de la disponibilité et du marché des drogues. Ces données indiquent plutôt l'impact des mesures de répression actives et passives.

> [Traduction] *« Les saisies seront probablement passives en ce sens qu'on assiste à un nombre plus ou moins constant de saisies en raison des opérations de surveillance et d'enquête habituelles. Plus la quantité de drogues arrivant sur le marché est importante, plus le nombre de saisies sera élevé du point de vue strictement statistique. Les saisies passives indiquent ainsi de façon positive la taille du marché. Cependant, les opérations policières en matière de drogues ont également un effet actif. Les enquêtes réalisées à partir de renseignements criminels mènent souvent à la fermeture des sources d'approvisionnement et à l'élimination d'importantes quantités de ces produits du marché domestique. Les saisies de ce type ont un effet négatif sur la taille du marché en ce sens qu'elles limitent l'approvisionnement plutôt que d'en indiquer la croissance. Lorsque ces deux facteurs sont en présence, il est difficile de tirer des conclusions évidentes sur l'approvisionnement à partir des renseignements touchant les saisies. »*[79]

Si, dans certains cas et pour certains pays, les saisies passives peuvent effectivement constituer un indicateur positif de la taille du marché, elles peuvent donner une lecture fausse du marché des drogues au Canada, nos vastes frontières et côtes maritimes ne facilitant pas la tâche des agents de police et de douanes d'arriver à des niveaux constants d'interceptions et de saisies. Les importateurs découvrent sans cesse de nouveaux moyens pour contourner les autorités en faisant appel à de nouveaux moyens d'entrée, ainsi qu'à des cargaisons plus importantes mais moins fréquentes, ou vice versa.

Malgré ces limites des données sur les saisies, les tendances indiquent que les saisies de cannabis, en kilogrammes et sous forme de plantes, ont connu une augmentation passablement importante au cours des dernières années, surtout lorsqu'on les compare aux saisies de cocaïne et d'héroïne.

Ces données nous démontrent aussi que la police a accordé une importance accrue aux infractions liées à la culture de la marijuana. En 1993, la police a saisi moins de 250 000 plants de marijuana, alors qu'elle en a saisi plus de 1 350 000 en 2001. Cela pourrait nous porter à croire qu'on a intensifié la culture au Canada et que la police priorise maintenant les infractions liées à la culture.

CONCLUSIONS

Conclusions du chapitre 14

[79] *Ibid.*

- **Nous estimons que les coûts de la lutte antidrogues au Canada varient entre 700 millions $ et 1 milliard $.**
- **La réduction des activités d'exécution de la loi résultant d'une modification des lois antidrogues touchant le cannabis pourrait entraîner des économies substantielles ou faire en sorte que les forces policières réaffectent des sommes considérables à d'autres priorités.**
- **En raison de la nature consensuelle des infractions liées aux drogues, on a accordé à la police des pouvoirs d'exécution substantiels et adopté des techniques d'enquête très intrusives. Cependant, ces pouvoirs ne sont pas illimités et ils font l'objet d'un examen de la part des tribunaux canadiens.**
- **Plus de 90 000 incidents liés à la drogue sont rapportés chaque année par la police. Plus des trois quarts de ces incidents touchent le cannabis et plus de 50 % de tous les incidents liés à la drogue concernent la possession de cannabis.**
- **De 1991 à 2001, la variation du taux en pourcentage par 100 000 de population pour ce qui est des infractions liées au cannabis est de +91,5 ; ainsi, le taux d'infractions liées au cannabis a presque doublé au cours des dix dernières années.**
- **Les incidents rapportés en matière de culture du cannabis ont connu une augmentation dramatique au cours des dix dernières années.**
- **Les taux d'incidents rapportés varient d'une province à l'autre.**
- **Le cannabis a fait l'objet de 70 % des +/- 50 000 accusations portées en 1999. Dans 43 % des cas (soit 21 381), l'accusation était liée à la possession de cannabis.**
- **Les taux d'accusations pour infractions liées à la drogue varient considérablement d'une province à l'autre.**
- **L'application inégale de la loi suscite des inquiétudes en ce qu'elle peut mener à des formes de discrimination, à l'aliénation de certains groupes de la société, et à la création d'une atmosphère d'irrespect envers la loi ; de façon générale, elle soulève la question de l'équité et la justice.**
- **Les statistiques sur les saisies sembleraient confirmer une intensification de la culture du cannabis au Canada et un déplacement des priorités de la police en ce qui a trait à cette infraction.**

CHAPITRE 15

LE SYSTÈME DE JUSTICE PÉNALE

Le chapitre précédent a examiné les rôles et pratiques des agences d'application de la loi qui sont la porte d'entrée du système de justice pénale. Que se passe-t-il après l'arrestation et la mise en accusation pour une infraction relative aux drogues ? Qui est responsable des poursuites et comment se font-elles ? Quel type de sanction les personnes condamnées reçoivent-elles ? Qui aura un casier judiciaire ? Et comment les tribunaux ont-ils interprété la validité de la loi sur les drogues ? C'est à ces questions que ce chapitre tente de répondre.

POURSUITES

Le Service fédéral des poursuites (SFP) du ministère de la Justice est l'agence principale en matière de poursuites des infractions relatives aux drogues au Canada. Bien que son mandat consiste à intenter des poursuites dans chaque province et chaque territoire en vertu des lois fédérales, son travail consiste principalement en poursuites relatives aux drogues en vertu de la LRDS.

En vertu de la LRDS, les provinces peuvent mener les poursuites si une procédure relative aux drogues a été engagée à la demande du gouvernement provincial. Présentement, seulement deux provinces (le Québec et, dans une moins grande mesure, le Nouveau-Brunswick) ont exercé ce pouvoir. Au Québec, le SFP n'intente des poursuites qu'à l'égard d'infractions qui ont fait l'objet d'enquêtes par la GRC. Dans le reste du Canada (à l'exception du Nouveau-Brunswick), le service intente des poursuites à l'égard d'infractions en matière de drogues qui ont fait l'objet d'enquêtes par des corps policiers provinciaux ou municipaux, ou par la GRC.

Le SFP emploie plus de 300 avocats internes à temps plein dans 13 bureaux partout au pays et environ 750 agents permanents du secteur privé effectuant des poursuites en matière de drogues au nom du procureur général du Canada. De manière générale, la police enquête au sujet de l'infraction et dépose une accusation qui sera suivie d'une poursuite, mais dans certaines provinces (telles la Colombie-Britannique, le Québec et le Nouveau-Brunswick), la police doit demander l'approbation de la Couronne avant de déposer une accusation.

Bien que les affaires complexes représentent encore un pourcentage assez bas des poursuites menées par le SFP, elles deviennent plus courantes et prennent déjà beaucoup de temps aux procureurs.

> *« …La plupart des affaires sont d'une complexité faible ou moyenne, mais la complexité des cas augmente. On estime actuellement que les affaires complexes représentent 7 % du temps des procureurs. Les affaires complexes associées au crime organisé nécessitent la participation du ministère de la Justice dès le stade initial à cause des questions légales liées à la collecte, à l'organisation et à l'admissibilité de la preuve. »*[1]

Le coût total des poursuites reliées aux drogues effectuées par le SFP, s'élève à environ 57 millions $ par année (35 millions $ pour les avocats internes et 22 millions $ pour les agents permanents). Le SFP estime que pour l'année 2000-2001, le coût des poursuites pour possession de cannabis, par rapport au budget global de 57 millions $, s'élevait à environ 5 millions $, soit 10 % du budget total.[2]

TRIBUNAUX

Nous avons peu d'information sur les coûts des poursuites reliées aux drogues, pour le système de tribunaux provinciaux. L'étude du CCLAT sur les coûts des drogues au Canada dont nous avons parlé au chapitre précédent[3] estimait les coûts judiciaires pour 1992 à environ 60 millions $. Avec près de 50 000 personnes par année accusées d'infractions reliées aux drogues et compte tenu de la complexité accrue de certaines affaires, on pourrait penser que ces coûts seraient beaucoup plus élevés que ceux estimés en 1992.

Une estimation de la vérificatrice générale indique qu'en 1999 les tribunaux de juridiction criminelle canadiens ont entendu 34 000 affaires de drogues illicites nécessitant plus de 400 000 comparutions.[4] D'autres coûts reliés aux tribunaux sont les ressources financières considérables dépensées pour l'aide juridique. En 1996/1997, 860 millions $ ont été dépensés pour les coûts administratifs des tribunaux et en

---

[1] *Rapport de la vérificatrice générale du Canada 2001,* Chapitre 11 – Les drogues illicites : Le rôle du gouvernement fédéral, page 13.

[2] Croft Michaelson, directeur et avocat général principal, Section de l'élaboration des politiques stratégiques en matière de poursuites, Justice Canada, Témoignage devant le Comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, Fascicule nº 22, page 54.

[3] Single, E., et coll., (1996) *Les coûts de l'abus des substances au Canada : Une étude sur l'estimation des coûts,* Ottawa : Centre canadien de lutte contre l'alcoolisme et les toxicomanies.

[4] *Rapport de la vérificatrice générale du Canada 2001,* Chapitre 11 – Les drogues illicites : Le rôle du gouvernement fédéral, page 4.

1997/1998, 455 millions $ ont été dépensés pour l'aide juridique.[5] Nous ne pouvons dire quelle partie de ces montants concerne les affaires de drogues illicites.

Les tribunaux de traitement de la toxicomanie

Le comité a visité le premier tribunal de traitement de la toxicomanie (TTT) durant son voyage à Toronto. Établi en 1998 à titre de projet pilote grâce au soutien financier de la Stratégie nationale sur la sécurité communautaire et la prévention du crime, ce projet réunit plusieurs acteurs incluant Justice Canada, le Solliciteur général du Canada, le SFP, le gouvernement de l'Ontario, le tribunal provincial, le Centre de toxicomanie et de santé mentale (CTSM), le service de police de Toronto, le service de santé publique de la ville de Toronto et divers organismes communautaires. Ce projet est actuellement financé jusqu'en décembre 2004.

Un deuxième projet pilote a été établi à Vancouver en décembre 2001. Ce projet utilise aussi un modèle intersectoriel et il doit servir à assurer une gestion intensive des affaires et à relier les participants aux ressources communautaires et aux programmes de développement des compétences, au besoin.

À Toronto le Centre de toxicomanie et de santé mentale de l'Ontario fournit les services de traitement aux contrevenants qui ont des dépendances, tandis qu'à Vancouver ils sont assurés par divers organismes locaux.

Partant de la prémisse, établie par de nombreuses études, que l'incarcération seule ne mène pas à une réduction de la consommation ni de l'activité criminelle s'y rattachant, les tribunaux de traitement de la toxicomanie ont pour objectif de fournir une réponse plus appropriée aux besoins des contrevenants qui ont des problèmes de dépendances. Le système de justice pénale ne dispose généralement pas des outils lui permettant d'adapter la sanction aux besoins propres des « toxicomanes » ni aux facteurs qui peuvent être à l'origine de cette dépendance (p. ex., chômage, itinérance, violence physique ou sexuelle subie durant l'enfance, discorde familiale, et autres problèmes de santé mentale et physique). Les TTT se basent sur des recherches démontrant que les programmes de traitement des toxicomanes sont plus efficaces que les sentences traditionnelles pour réduire la criminalité et la récidive chez ces personnes. Patricia Begin, du Centre national pour la prévention du crime du ministère de la Justice ajoutait :

> *« Autre hypothèse sous-jacente : par les approches axées sur la jurisprudence thérapeutique tels les tribunaux chargés des affaires de drogue qui visent à assurer la réadaptation et la réintégration des contrevenants-toxicomanes, le système de justice pénale, de concert avec les organismes de traitement et les*

[5] Statistique Canada, Centre canadien de la statistique juridique, *Juristat*, Dépenses de la justice au Canada, catalogue 85-002-XIE vol. 19, nº 12, pages 7-9.

services communautaires, peut servir d'agent de changement et contribuer à modifier le cheminement de vie du toxicomane. »[6]

Le TTT de Toronto fournit un traitement supervisé par le tribunal pour les personnes présentant une dépendance à la cocaïne et/ou aux opiacés. Les contrevenants non violents accusés de possession ou de trafic de petites quantités de crack/d'héroïne, ou accusés d'infractions liées à la prostitution, sont éligibles au programme. Dans tous les cas, l'organisme de traitement assure la sélection et l'évaluation des personnes. L'admission est volontaire mais doit être approuvée par la Couronne. Les facteurs considérés incluent les autres accusations criminelles courantes, le risque encouru pour la communauté et la gravité et les circonstances entourant l'infraction. Deux parcours ont été établis. Généralement, le premier parcours est destiné aux personnes ayant un casier judiciaire limité ou n'en possédant pas et qui sont accusées de possession simple. Elles sont éligibles à participer au programme avant l'enregistrement du plaidoyer – une fois le programme complété, l'accusation est suspendue ou retirée. Le deuxième parcours s'adresse aux contrevenants possédant un dossier criminel plus grave ou qui sont accusés de trafic. Ils doivent plaider coupable – une fois la phase I du programme complétée, le contrevenant reçoit une sentence non privative de liberté et il est mis en liberté surveillée (phase II). À défaut de compléter la phase I, le contrevenant se verra expulsé et condamné.

Le système se base sur une collaboration étroite entre le tribunal et les organismes de traitement. Les contrevenants comparaissent régulièrement devant le tribunal – celui-ci siège deux fois par semaine – où le juge, en consultation avec l'équipe de traitement du TTT, passe en revue les progrès qu'ils ont réalisés. L'équipe du TTT inclut le juge du TTT, le procureur de la Couronne, l'avocat de service, le représentant des services de probation, le personnel du tribunal, le personnel de liaison entre la communauté et le tribunal, et ceux travaillant au traitement. Des décisions ayant trait au traitement futur et à l'implication judiciaire sont prises. La conformité aux étapes du processus est encouragée au moyen d'un système de récompenses et de sanctions graduées – remise en liberté provisoire du contrevenant assortie de conditions appropriées auxquelles il doit se conformer. La possibilité de rechute fait partie intégrante du processus de réadaptation et elles ne mènent pas automatiquement à l'expulsion. L'honnêteté et la responsabilité sont toutefois importantes. Le non-respect d'autres conditions telles que la comparution au tribunal ou d'avoir omis de fournir un échantillon d'urine, peut résulter en diverses sanctions incluant la révocation de la mise en liberté pour une période allant jusqu'à cinq jours.

Chaque participant est engagé dans un programme de traitement ambulatoire adapté à ses besoins spécifiques. Le traitement dure environ une année pendant

---

[6] Patricia Bégin, directrice, Recherche et évaluation, Centre national de prévention du crime, Délibérations du comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001-2002, Fascicule nº 22, page 57.

laquelle le contrevenant travaille étroitement avec un superviseur. Le traitement comprend : un counselling individuel et en groupe, une gestion continue du cas, le dépistage périodique et aléatoire de la consommation de drogues, et des services médicaux de toxicomanie – incluant le maintien à la méthadone lorsque nécessaire. Le personnel thérapeutique collabore aussi étroitement avec les organismes communautaires et les agences du système judiciaire pour répondre aux besoins des participants. Pour compléter le programme, le contrevenant ne doit pas avoir consommé de crack/de cocaïne et/ou d'héroïne pendant une période prolongée et il doit aussi démontrer un changement fondamental dans son style de vie impliquant l'amélioration de ses habiletés interpersonnelles, des conditions de logement stables et appropriées, et une démarche réussie en matière d'éducation et d'orientation professionnelle.

L'initiative du TTT semble être un pas dans la bonne direction mais il faudra attendre les résultats des évaluations en cours pour connaître l'efficacité de cette mesure. Même aux États-Unis, où ces programmes existent depuis le début des années 1980, peu d'évaluations rigoureuses de leurs impacts ont été effectuées. La plupart ont été effectuées sur une période de temps limitée, n'incluant pas un suivi à long terme afin de déterminer s'il y avait rechute ou abus de drogues et récidivisme criminel, et elles présentent des lacunes méthodologiques notamment sur les groupes témoins permettant l'attribution des effets constatés aux interventions du programme. Il est difficile aussi de comparer les projets canadiens avec les expériences américaines puisque les sentences minimales et des pénalités plus sévères imposées en général aux USA constituent un incitatif important pour les participants américains à demeurer dans le programme.[7]

Patricia Bégin, directrice de la recherche et de l'évaluation au Centre national de prévention du crime, a fourni les détails préliminaires suivants sur le TTT de Toronto :

> *« Brièvement, l'évaluation à Toronto repose sur une approche quasi expérimentale. Le groupe témoin se compose des « clients » jugés admissibles au programme mais qui ont décidé de ne pas participer, préférant plutôt passer par les voies classiques de la justice pénale.*
>
> *Entre avril 1999, moment où on a commencé à rassembler les données en vue de l'évaluation, et le 5 octobre 2001, 284 personnes ont été inscrites au programme. 83 %, soit 234 personnes, forment le groupe expérimental, et cinquante (17 %) forment le groupe témoin.*
>
> *Dans le groupe expérimental, 16,7 % des partiapants sont encore inscrits au programme ; 13,7 ou 14 % l'ont terminé avec succès, c'est-à-dire 32 personnes ; et 62 % ont été expulsés. Le taux de rétention total se situe à 31 %.*

[7] Patricia Bégin, directrice, Recherche et évaluation, Centre national de prévention du crime, Délibérations du comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001-2002, Fascicule nº 22, page 58.

Un aspect que la recherche a permis de mettre en lumière, c'est que le taux de rétention atteint 50 % lorsque les participants dépassent le cap des trois mois. Le tribunal essaie, par l'entremise des données, de mieux comprendre les caractéristiques des clients jugés admissibles mais qui ne réussissent pas et qui sont expulsés ou qui se retirent durant les trois premiers mois.

...L'évaluation a permis de constater que le groupe témoin est plus susceptible d'être formé de jeunes sans emploi ayant une activité illégale comme source de revenu, ayant un casier judiciaire et ayant été mis en prison plus souvent et accusés plus souvent d'une nouvelle infraction depuis leur inscription au tribunal des affaires de drogue. À bien des égards, le groupe témoin présente un risque beaucoup plus élevé que le groupe expérimental.

Le taux de récidive moins élevé noté chez les bénéficiaires du programme de tribunal des affaires de drogue et des services connexes est peut-être lié à leur degré de risques. Nous aimerions approfondir la question de savoir si ces différences sont attribuables à la participation au programme ou au degré moindre de risque et à la motivation de changer sa vie.

Les données de l'évaluation dont nous disposons jusqu'à maintenant nous révèlent ce qui suit : le tribunal des affaires de drogue à Toronto est capable de mobiliser les contrevenants et de les faire persévérer. Ceux qui persévèrent ont tendance à terminer le programme avec succès, et les données de suivi limitées ayant été réunies jusqu'à maintenant semblent indiquer qu'ils présentent bel et bien un taux de récidive moins élevé qu'ils consomment moins de drogue.

Il y a aussi une réduction de la consommation de drogue et de l'activité criminelle chez les contrevenants pendant qu'ils participent au programme. Le taux de réarrestation a tendance à être moins élevé chez le groupe sujet que chez ceux qui ont été expulsés ou qui font partie du groupe témoin. Un des défis de l'évaluation, pour les quelques années à venir, consistera à mieux apparier les groupes de manière à définir les résultats, les impacts et les effets du tribunal sous certains aspects clés, qui touchent la consommation de drogue, l'activité criminelle, la réinsertion « prosociale » au sein de la collectivité, la stabilité familiale et les choses de cette nature. »[8]

Nous suivrons avec intérêt les résultats de cette évaluation. Notons tout de même au passage que le coût d'incarcération en Ontario par personne s'élève à environ 45 000 $ par année, tandis que les coûts annuels de traitement des TTT sont évalués à 4 500 $ par personne. Il est évident que cette approche pourrait mener à des économies importantes pour le système de justice pénale tout en contribuant à réduire les problèmes de dépendances aux drogues et de criminalité afférente chez un certain nombre de personnes.

[8] Patricia Bégin, directrice, Recherche et évaluation, Centre national de prévention du crime, Délibérations du comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001-2002, Fascicule nº 22, pages 58-60.

DÉCISION ET DÉTERMINATION DE LA SANCTION

Les faiblesses des informations statistiques dont nous avons déjà discuté sont particulièrement évidentes en ce qui a trait aux décisions ainsi qu'à la détermination des sanctions liées aux drogues illicites. La vérificatrice générale avait aussi soulevé cette question dans son rapport 2001.

« Certains volets des statistiques sur l'application de la loi comportent des lacunes. Tout d'abord, il n'existe pas de statistiques nationales sur les condamnations et les peines infligées relativement aux drogues illicites. Ainsi, la Colombie-Britannique, le Manitoba, le Nouveau-Brunswick et le Nunavut ne fournissent pas à Statistique Canada de données sur les tribunaux pénaux pour adultes. L'utilisation des statistiques requiert une bonne analyse et une bonne interprétation pour comprendre les tendances et les causes sous-jacentes. Étant donné que le Canada ne possède pas de données nationales, il ne peut suivre des tendances importantes comme celles relatives à la durée des peines à l'apparition de nouvelles drogues ou aux écarts régionaux…

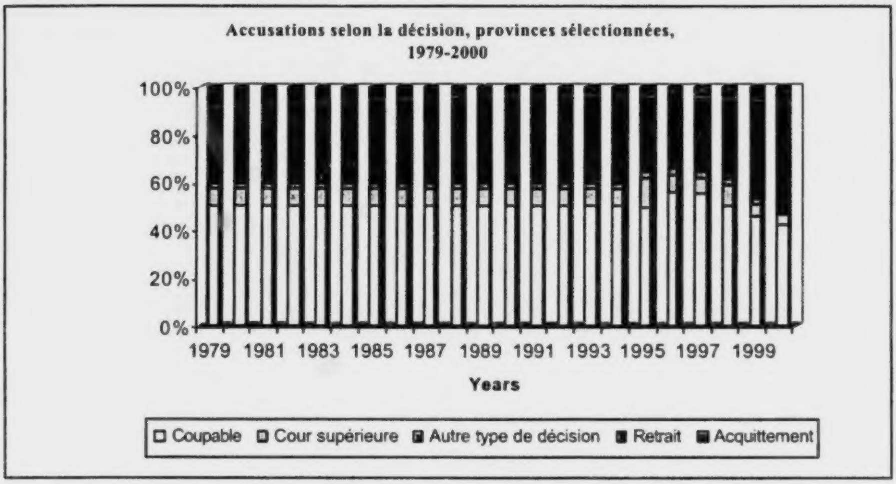
Une deuxième lacune vient du fait que les statistiques sur les condamnations et les peines relatives aux drogues sont déclarées selon les catégories visées par la Loi réglementant certaines drogues et autres substances, et ne sont pas très détaillées. Alors que les statistiques nationales sur les mises en accusation par la police répartissent le nombre d'accusations liées aux drogues selon le type de substance (par exemple, héroïne, cocaïne et cannabis) et le type d'infraction (par exemple, possession, trafic, importation et culture), les statistiques sur les condamnations ne sont réparties qu'en deux catégories – possession et trafic. Le rapport 1999-2000 publié par la Commission interaméricaine de lutte contre l'abus des drogues, qui fait état des progrès du Canada en matière de réglementation des drogues, signale la nécessité d'améliorer les statistiques judiciaires sur les infractions liées aux drogues. »[9]

Malgré ces faiblesses, nous examinons certaines données dans les pages suivantes.

Le graphique suivant présente les résultats pour ceux qui sont accusés d'infractions reliées aux drogues dans certaines provinces. Il semble qu'à compter de 1995, il y ait eu une augmentation assez importante du pourcentage d'inculpés dont l'accusation a été suspendue ou retirée, d'où la diminution du pourcentage d'accusés trouvés coupables. Il faut cependant noter que ce graphique n'inclut pas les données de trois provinces (Nouveau-Brunswick, Manitoba et Colombie-Britannique) et d'un des territoires (Nunavut). De plus, les données de certains tribunaux du Québec n'y sont pas incluses. Notons enfin que les données avant 1995 sont basées sur des approximations établies à partir de la répartition moyenne des accusations durant la période couvrant les années 1995 à 2000.

---

[9] *Rapport de la vérificatrice générale du Canada 2001,* Chapitre 11 – Les drogues illicites : Le rôle du gouvernement fédéral, page 15.



En 1996-1997, 64 % des personnes accusées de trafic de drogue ont été condamnées à une incarcération. La durée moyenne de la sentence était de quatre mois. La mise en liberté surveillée était la sentence la plus importante dans 24 % des affaires et l'amende dans 9 % des cas.[10]

Pour les infractions de possession, une amende était imposée dans 63 % des cas, d'un montant moyen de 200 $. L'amende était la sentence la plus importante dans 55 % des cas, la mise en liberté surveillée dans 22 % des cas et la détention dans 13 % des cas.[11]

Nous avons été informés que le SFP tente d'identifier et de mettre en œuvre des mesures de déjudiciarisation lorsqu'elles sont appropriées, par exemple pour les contrevenants accusés pour la première fois de possession simple de cannabis. Les projets pilotes de TTT à Toronto et à Vancouver, font aussi partie des mesures de rechange. De même, un « projet pilote de poursuite différée » est en cours au Manitoba où les procureurs demandent un engagement de ne pas troubler la paix publique pour les contrevenants accusés de possession de cannabis. Dans ces affaires, les accusations seraient suspendues pendant un an et, si le contrevenant ne revient pas devant le système judiciaire, l'affaire est alors classée. D'autres programmes de « déjudiciarisation » à travers le Canada nous ont été mentionnés.[12]

---

[10] Statistique Canada, Centre canadien de la statistique juridique, *Juristat*, Drogues illicites et criminalité au Canada, février 1999, page 7.

[11] *Ibid.*

[12] Croft Michaelson, directeur et avocat général principal, Section de l'élaboration des politiques stratégiques en matière de poursuites, Justice Canada, Délibérations du comité spécial sur les drogues

Bien que les données relatives aux décisions et aux peines soient faibles, quelques études nous donnent un aperçu de ce qui se passe au Canada. Un document préparé par le Comité permanent de lutte à la toxicomanie examine les pratiques policières et judiciaires au Québec de 1985 à 1998.[13] Le rapport démontre que les pratiques varient non seulement entre les régions du pays mais aussi à l'intérieur même de la province de Québec. Le rapport observe aussi que la déjudiciarisation des affaires de possession de cannabis est loin d'être une pratique courante et qu'on utilise ce recours davantage dans les affaires impliquant des mineurs où elle est en hausse (20,6 % en 1990, 48,2 % en 1995, 55,9 % en 1996 et 63 % en 1997). Ici aussi, les pratiques varient considérablement d'une région à l'autre. Environ 80 % des personnes accusées de possession de cannabis étaient des adultes, presque tous des hommes (environ 90 %). Le rapport indiquait que les sanctions n'étaient pas sévères, particulièrement où il était question d'une seule infraction. Pour les adultes, les sanctions imposées étaient principalement des amendes et la mise en liberté surveillée, exceptionnellement la détention. Pour les mineurs, la sanction la plus courante était le travail communautaire ou la mise en liberté surveillée ; la détention était rarement imposée. Les données pour Montréal en 1998 indiquent que l'incarcération pour possession de cannabis est moins probable (13,8 % de toutes les sanctions) que pour les autres substances, et que de telles sanctions sont plus courtes (50 % étaient d'une journée et aucune ne dépassait 10 jours). De plus, les amendes étaient moins élevées (les amendes moyennes pour le cannabis s'élevaient à 186 $ tandis qu'elles s'élevaient à 277 $ pour la cocaïne).

Patricia Erickson, une chercheure au Centre de toxicomanie et de santé mentale, a mené trois études à Toronto en 1974, en 1981 et en 1998 sur les personnes accusées de possession de cannabis. Ces études indiquent que les délinquants dans les affaires liées au cannabis étaient, en vaste majorité, des jeunes hommes (environ 90 % sont de sexe masculin et plus de la moitié sont âgés de 21 ans ou moins). La plupart (80 %) occupaient un emploi ou étaient étudiants, et environ la moitié vivaient avec les parents. La plupart des affaires impliquaient un seul chef d'accusation pour possession simple et les quantités étaient minimes : dans plus de 75 % des affaires, il s'agissait d'une quantité inférieure à 14 grammes de cannabis. L'étude de 1998 démontrait même que 50 % des accusations concernaient des quantités d'un gramme ou moins.

Dans les deux premières études, une libération inconditionnelle ou sous condition était la sentence la plus fréquente, et en 1998, 43 % des cas avaient fait l'objet d'une mesure de déjudiciarisation. Selon l'auteure, les sanctions semblaient avoir été accordées de manière aléatoire et [traduction] «il n'y avait aucun lien entre la peine

---

illicites, Sénat du Canada, première session de la trente-septième législature, 2001-2002, Fascicule nº 22, pages 54-55.

[13] Comité permanent de lutte à la toxicomanie, *La déjudiciarisation de la possession simple de cannabis*, juin 1999, pages 11-13.

imposée et les caractéristiques du contrevenant ou de l'affaire, la nature des accusations et la quantité de drogue en cause. »[14]

Erickson au aussi examiné la question de la dissuasion. Sa première étude indiquait que 92 % des contrevenants consommaient toujours un an plus tard (dans les études subséquentes, environ 80 % avaient l'intention de consommer ou consommaient encore). De plus, les données indiquaient que la sévérité de la sanction n'était pas reliée à la décision de consommer dans le futur. En fait, le meilleur prédicteur de la cessation de consommation après avoir été criminalisé était la quantité consommée par le contrevenant par le passé – moins la consommation était élevée, plus grandes étaient les probabilités qu'il cesse de consommer. Il n'y avait pas non plus d'indications que la judiciarisation avait des effets de dissuasion générale, même si l'auteure admettait que cette question est beaucoup plus difficile à mesurer.

Bien qu'elles soient une amélioration certaine de la réponse du système de justice traditionnel, les mesures de déjudiciarisation semblent élaborées de manière ad hoc et ne sont pas disponibles de la même manière à travers le pays. Par conséquent, des contrevenants qui pourraient en bénéficier n'y ont pas accès. De plus, les critères d'admission aux diverses mesures semblent diverger selon les programmes. Il en résulte une application inégale de la loi où des contrevenants ayant commis des infractions sont traités différemment selon leur lieu de résidence.

SERVICE CORRECTIONNEL

Le Service correctionnel du Canada (SCC) est responsable des contrevenants purgeant une peine d'emprisonnement de deux ans ou plus, incluant les individus reconnus coupables d'infractions graves liées à la drogue. Le SCC estime que :

- Près de 70 % des contrevenants (dans le système judiciaire fédéral) ont des problèmes d'alcool et/ou de drogues ;
- Plus de la moitié consommaient des drogues ou de l'alcool lorsqu'ils ont commis le délit pour lequel ils sont incarcérés ; et
- Environ 20 % des contrevenants en prison ont été reconnus coupables d'infractions reliées aux drogues.

Ces statistiques indiquent que l'abus de substance devrait constituer une haute priorité pour le SCC. Cela soulève deux questions : 1) comment répondre aux enjeux de la disponibilité des drogues dans les établissements fédéraux ?, et 2) comment

[14] Dr Patricia Erickson, recherchiste, Centre de toxicomanie et de santé mentale, Délibérations du comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001, Fascicule nº 2, page 90.

fournir les services de réadaptation aux détenus aux prises avec des problèmes de consommation de substances ?

En ce qui a trait aux mesures de sécurité, le SCC effectue des fouilles, des analyses d'échantillons d'urine et travaille avec la police pour partager les renseignements relatifs aux problèmes de drogues. De plus, des détecteurs ioniques ont récemment été installés dans chaque établissement pour aider à détecter l'introduction de drogues. Il est aussi question d'avoir un chien-détecteur de drogues dans chaque établissement. Malgré toutes ces mesures de sécurité, il serait difficile pour le SCC d'affirmer qu'ils gardent avec succès les substances psychoactives hors des pénitenciers. Les résultats nationaux provenant d'une analyse aléatoire d'échantillons d'urine en 2001-2002 démontraient que 12 % des échantillons étaient positifs pour au moins une drogue.[15] De plus, une étude récente effectuée dans les établissements au Québec démontre que 29 % des détenus admettent consommer des drogues illicites, la plupart d'entre eux consommant du cannabis.

> *« L'incarcération ne résout pas nécessairement le problème. Une étude que nous avons menée récemment dans les pénitenciers canadiens de la région du Québec montre qu'il y a consommation à l'intérieur même des murs. Nous avons demandé aux détenus de nous indiquer leur consommation dans les trois derniers mois alors qu'ils étaient incarcérés - ce sont tous des hommes détenus - et 16 % nous ont dit qu'ils avaient consommé de l'alcool, tandis que 29 % nous ont dit qu'ils avaient consommé des drogues illicites. Dans la majorité des cas, il s'agit de cannabis, alors que ces mêmes détenus consommaient de la cocaïne à l'extérieur. C'est un changement très appréciable. Pourquoi consomment-ils du cannabis alors que le cannabis est beaucoup plus détectable par l'odeur et par les traces qu'il laisse dans l'urine? On peut détecter le cannabis pendant 15 jours après sa consommation alors que la cocaïne n'est détectable que durant 48 heures au maximum. Le détenu veut s'évader. La cocaïne est un stimulant qui le ramène à sa réalité et ce n'est pas ce que le détenu désire, il veut s'évader. Ce sont les produits calmants qui ont la cote. Ce sont parfois des benzodiazépines. Mais on peut facilement se procurer du cannabis. »*[16]

Le SCC offre divers programmes de traitement aux détenus aux prises avec des problèmes de drogue, pour les aider à briser le cycle de dépendance et à réintégrer la communauté. Ces programmes incluent le programme de prévention de la toxicomanie, le programme CHOIX et un programme pour les détenus qui purgent une longue peine. Le SCC a aussi créé des unités de soutien intensif prévoyant des vérifications et des tests accrus pour soutenir le détenu dans ses efforts pour changer son comportement face à la toxicomanie. Le bureau de la vérificatrice générale évalue

---

[15] Paul E. Kennedy, sous-solliciteur général adjoint principal, Secteur de la police et de la sécurité, Solliciteur général du Canada, Délibérations du comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001-2002, Fascicule nº 22, page 10.

[16] Serge Brochu, professeur, Université de Montréal, Délibérations du comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001, Fascicule nº 12, pages 23-24.

que 53 % des détenus participent à des programmes de traitement pour toxicomanes pendant qu'ils purgent leur peine.[17]

En ce qui a trait à la réduction des méfaits, le SCC fournit le traitement à la méthadone à certains toxicomanes s'injectant des opiacés et met à la disposition des détenus de l'eau de Javel pour stériliser les aiguilles. Le SCC met aussi en pratique d'autres initiatives de prévention des maladies contagieuses telle la vaccination contre l'hépatite B. Au début de l'année 2002, le SCC a annoncé un programme de traitement à la méthadone plus étendu pour les détenus des pénitenciers fédéraux toxicomanes consommant de l'héroïne et d'autres opiacés.

Le Centre de recherche en toxicomanie (CRT) du SCC, créé à Montague à l'Île-du-Prince-Édouard en mai 2001, a pour mandat d'effectuer des études appliquées pour aider les Services correctionnels à mieux comprendre les questions entourant la toxicomanie chez les détenus et élaborer des programmes efficaces de traitement de la dépendance. C'est le seul centre de recherche établi par un organisme correctionnel qui s'adresse spécialement aux défis de la toxicomanie. Avec un personnel de 20 employés, le centre concentre ses activités de recherche sur quatre domaines : l'élaboration de programme (programmes de sensibilisation culturelle pour les femmes et les détenus autochtones) ; la recherche sur les programmes (dans des secteurs tels que l'intervention communautaire, la méthadone, les unités de soutien intensif et le syndrome d'alcoolisme fœtal) ; l'évaluation et la surveillance (pour mesurer les tendances et évaluer le succès des interventions) ; et la diffusion des connaissances.

Le principal poste de dépenses du SCC correspond à l'incarcération. Le bureau de la vérificatrice générale a évalué qu'en 1999, le SCC a dépensé 169 millions $ pour les drogues illicites : 154 millions $ pour les détenus purgeant des peines en totalité ou en partie pour des infractions reliées aux drogues ; 8 millions $ pour les programmes de lutte contre la toxicomanie (incluant l'alcoolisme) ; 4 millions $ pour les programmes de traitement (p. ex. la méthadone) ; et 3 millions $ pour effectuer des analyses d'échantillons d'urine. Les coûts des mesures de sécurité pour contrôler l'approvisionnement de drogues dans les établissements étaient inconnus.[18] Estimant la population actuelle des détenus fédéraux à 13 000 individus, si environ 7000 d'entre eux participent aux programmes de traitement pour les toxicomanes pendant qu'ils purgent leur peine, c'est dire que les services correctionnels dépensent environ 1 150 $ par détenu pour les programmes de traitement.

Au 31 décembre 2000, 5 779 contrevenants trouvés coupables d'infractions liées aux drogues étaient sous juridiction fédérale (purgeant leur peine soit dans un établissement fédéral soit en libération conditionnelle). Parmi ceux-ci, 3 890 purgeaient des peines pour trafic, 621 pour importation, 225 pour culture et 2 221 pour

[17] *Rapport de la vérificatrice générale du Canada 2001*, Chapitre 11 – Les drogues illicites : Le rôle du gouvernement fédéral, page 15.

[18] *Rapport de la vérificatrice générale du Canada 2001*, Chapitre 11 – Les drogues illicites : Le rôle du gouvernement fédéral, page 18.

possession.[19] Parmi les 2 548 purgeant leur peine dans un établissement correctionnel fédéral la répartition est la suivante : 1 613 pour trafic, 113 pour importation, 82 pour la culture et 1 318 pour possession.[20] Rappelons que les détenus purgeant leur peine dans des établissements fédéraux ont été condamnés à la détention pour deux ans ou plus. Pour les 3231 en libération conditionnelle la répartition selon les infractions est la suivante : 2 312 pour trafic, 508 pour importation, 145 pour culture et 946 pour possession.[21]

Entre 1995 et 2000, la population carcérale totale pour les infractions liées aux drogues dans le système fédéral a augmenté de presque 9 %. Une bonne partie de cette augmentation est reliée à ceux qui sont en liberté conditionnelle, étant donné que ce groupe a augmenté de 19 % pendant cette période. Durant la même période, le nombre d'individus purgeant leur peine dans les établissements a diminué de 2 %.[22]

À la fin de l'an 2000, la durée moyenne de l'emprisonnement pour infraction liée aux drogues était de 2,2 années, et la durée moyenne des libérations conditionnelles était de 3,7 années, durées moyennes inférieures à celles des autres infractions (non liées aux drogues). Nous observons aussi que le temps moyen purgé en détention pour les infractions de possession était de 2,52 années, tandis qu'il s'élevait à 1,89 année pour trafic, à 1,48 année pour importation et à 0,88 année pour culture. Pour les libérations conditionnelles, le temps moyen purgé pour importation était de 4,6 années, tandis qu'il s'élevait à 3,6 années pour possession, à 3,5 années pour trafic et à 2,2 années pour culture.[23] Selon le SCC, le fait que les contrevenants semblent purger plus de temps pour les infractions de possession que pour les autres infractions liées aux drogues telles que le trafic, s'expliquerait par le fait qu'ils purgent souvent des peines pour d'autres infractions, plus graves, rendant les comparaisons extrêmement difficiles.

Le graphique suivant présente les données relatives au nombre d'admissions par région dans les établissements correctionnels fédéraux en relation avec les infractions liées aux drogues pour l'année 2000 et le nombre de détenus incarcérés dans les différentes régions du pays, en date du 31 décembre 2000.

---

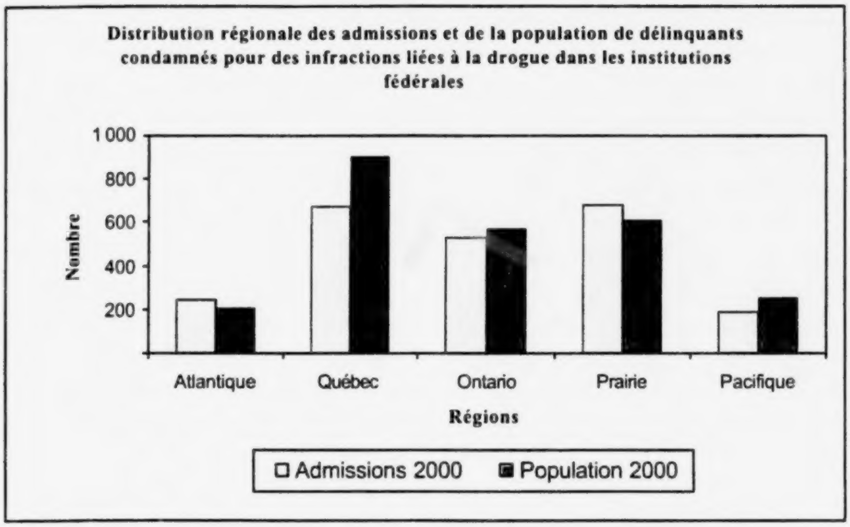
[19] Service correctionnel du Canada, Forum – Recherche sur l'actualité correctionnelle, volume 13, nº 3, septembre 2001, page 25. La possession en vue de faire du trafic est comprise dans les chiffres pour le trafic.

[20] *Ibid.* Certains contrevenants peuvent être représentés dans plus d'une catégorie d'infraction reliée aux drogues.

[21] *Ibid.* Certains contrevenants peuvent être représentés dans plus d'une catégorie d'infraction reliée aux drogues.

[22] *Ibid.*

[23] Service correctionnel du Canada, *Forum – Recherche sur l'actualité correctionnelle*, Profil de la population de délinquants condamnés pour une infraction liée à la drogue dans le système correctionnel fédéral canadien, septembre 2001, volume 13, nº 3, page 26.



CASIER JUDICIAIRE

Les conséquences d'une accusation criminelle sont multiples : avant le verdict il y a des coûts directs reliés à la comparution devant le système de justice pénale tels les frais juridiques, le temps passé à l'extérieur du travail, etc., et des coûts indirects lorsque l'accusé doit se présenter au poste de police. Il existe aussi des coûts émotionnels liés aux inquiétudes du fait d'être accusé d'une infraction criminelle. L'accusé subit ces coûts même s'il n'est pas trouvé coupable ou que l'accusation est retirée plus tard.[24]

Les sanctions imposées par les tribunaux constituent un autre coût évident pour les contrevenants, qu'il s'agisse d'une amende ou d'une période de probation. Finalement, il existe des coûts subséquents à une condamnation. Par exemple, une condamnation criminelle peut avoir un impact négatif sur les perspectives d'emploi et peut représenter un empêchement pour voyager à l'extérieur du pays. Les séquelles de la criminalisation affectent tous les contrevenants. Ceux qui reçoivent des sentences plus sévères se sentent généralement traités de manière injuste, ce qui peut mener à un manque de respect envers l'administration de la justice.[25]

Le criminaliste Allan Young a déclaré ce qui suit au Comité :

---

[24] Dr Patricia Erickson, recherchiste, Centre de toxicomanie et de santé mentale, Délibérations du comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001, Fascicule nº 2, pages 82-90.
[25] *Ibid.*

> *« Je reçois deux à trois appels par semaine de citoyens qui, si ce n'est qu'ils fument de la marijuana, sont autrement respectueux des lois, mais qui ont perdu leur emploi, se sont vu refuser l'entrée aux États-Unis ou l'accès à leurs enfants ou à des emplois au gouvernement. Ces gens ont été traités comme des criminels de droit commun. C'est le plus gros problème que pose l'interdiction de la marijuana : si vous traitez en criminels ceux qui, autrement, sont respectueux des lois, ils commenceront à perdre tout respect pour des gens comme M. Fontina et ceux qui s'efforcent de défendre et de protéger nos intérêts. »* [26]

En ce qui a trait aux coûts d'interdiction du cannabis, le Dr Patricia Erickson a indiqué que nous avons le choix.

> *« Il est évident que dans le contexte de la politique antidrogues des États-Unis, les personnes pour qui la consommation de drogue est une question d'ordre moral n'attachent pas d'importance au coût. Le coût leur importe peu. Ce qui leur importe, c'est de veiller à ce que la consommation de drogue soit considérée comme une mauvaise chose. Mais au Canada, nous avons toujours été plus pondérés et nous nous appuyons davantage sur les faits. C'est une nette distinction par rapport aux États-Unis. Les Canadiens peuvent au moins mesurer les coûts des politiques, en discuter et envisager d'autres solutions. Nous ne sommes pas prêts à payer n'importe quel prix. »* [27]

Une condamnation criminelle peut aussi constituer un facteur important lors de toute interaction future avec le système de justice pénale. Elle peut : influencer la décision d'un officier de police à porter une accusation là où il/elle aurait pu autrement utiliser son pouvoir discrétionnaire ; amener un procureur de la Couronne à choisir de poursuivre par voie de mise en accusation plutôt que par déclaration sommaire de culpabilité ; être utilisée dans certaines circonstances dans des procédures criminelles subséquentes ; et mener un juge à imposer une sanction plus sévère. Il ne s'agit pas là de conséquences triviales – surtout lorsqu'il s'agit d'un délit de possession de cannabis.

Qu'arrive-t-il en cas d'absolution conditionnelle ou inconditionnelle ? L'article 730 du *Code criminel* indique qu'une telle personne est réputée n'avoir jamais été déclarée coupable d'une infraction. Pourtant, il est probable que la plupart répondent affirmativement si on leur demande, sur un formulaire de demande d'emploi ou lors d'une entrevue, s'ils ont déjà été arrêtés, reconnus coupables ou ont déjà plaidé coupables pour une infraction criminelle.

Une condamnation ne signifie pas nécessairement que la personne a un « casier judiciaire », c'est-à-dire un dossier dans le système du Centre d'information de la police canadienne (CIPC). Ce système d'information informatisé utilisé par les services policiers fournit des renseignements relatifs aux crimes et aux criminels. La banque de données d'identification (une des quatre banques de données du CIPC), contient la

---

[26] Alan Young, professeur agrégé, Osgoode Hall Law School, Délibérations du comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001, Fascicule nº 5, page 27.

[27] Dr Patricia Erickson, recherchiste, Centre de toxicomanie et de santé mentale, Délibérations du comité spécial sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 2001, Fascicule nº 2, page 99.

fiche précise du casier judiciaire dans laquelle les données sont entrées, à partir de l'information contenue sur la fiche dactyloscopique. Ce dossier contient des données signalétiques (telles que l'état du dossier, la description du sujet, l'historique du sujet (casier, type d'infraction) et les noms d'emprunt du sujet). Le casier judiciaire complet est disponible sur demande dans toutes les agences desservies par des terminaux du CIPC.

Pour les contrevenants adultes, le casier judiciaire sera détruit dès que surviendra l'une des deux situations suivantes, soit trois ans après le décès de l'individu ou lorsque ce dernier atteindra l'âge de 80 ans (toutefois, dans certaines circonstances, cela ne s'applique pas, par exemple si la personne a été accusée au cours des dix dernières années). Les absolutions inconditionnelles ou conditionnelles seront retirées et archivées comme suit : pour une absolution inconditionnelle survenue le ou après le 24 juillet 1992, à l'expiration d'une période d'un an suivant la date de la sentence le casier judiciaire sera archivé pour une période de cinq ans et ensuite détruit ; pour une absolution conditionnelle survenue le ou après le 24 juillet 1992, à l'expiration d'une période de trois ans suivant la date de la sentence, le casier judiciaire est maintenu en archive pour une période de cinq ans et ensuite détruit. Toute libération précédant le 24 juillet 1992 sera détruite sur demande écrite. Lorsqu'un pardon est accordé, l'information relative à l'infraction est retirée du CIPC et est classée dans un endroit sûr, distinct et à l'écart des autres casiers judiciaires (les données sont détruites suivant les directives mentionnées plus haut). Suite à un acquittement, l'accusé peut faire une demande au service de police qui s'est occupé de l'affaire afin que l'information soit supprimée des dossiers de la police locale et de la GRC. La GRC acceptera de retourner les empreintes digitales de la personne et de retirer du CIPC les informations relatives à l'infraction seulement sur demande du service de police qui s'occupait de l'affaire. Des règlements spéciaux s'appliquent aux jeunes contrevenants.

Même si une personne n'a pas de « casier judiciaire », cela ne signifie pas que la personne n'a pas été reconnue coupable d'une infraction criminelle. Bien qu'il soit plus probable que l'existence d'un casier judiciaire puisse entraîner des conséquences négatives, les questions soulevées ci-dessus s'appliquent aussi à ceux qui ont été condamnés sans pour autant avoir de « casier judiciaire ». Selon les circonstances et la façon dont la question est formulée, l'absence de casier judiciaire peut ne pas être pertinente.

L'infraction pour possession de moins que 30 grammes de marijuana étant une infraction jugée sur déclaration sommaire de culpabilité, les empreintes digitales d'une personne ne devraient plus être relevées suite à son arrestation. Les empreintes digitales constituant la base du casier judiciaire, cette seule infraction ne devrait pas mener à la constitution d'un dossier judiciaire sur CPIC. Toutefois, avant la réforme de la loi en 1996, les personnes accusées de simple possession étaient sujettes à l'ouverture

d'un casier judiciaire et, au début des années 1990, plus de 500 000 Canadiens possédaient un casier judiciaire pour possession de cannabis.[28]

À cause de la complexité de cette situation, on peut se demander si les personnes qui ont été condamnées pour une infraction, quelle que soit la sentence imposée ou s'ils ont reçu un pardon, connaissent leurs droits. Par exemple, lorsqu'elles complètent un formulaire d'emploi, la plupart des personnes auraient probablement de la difficulté à répondre à certaines questions reliées à leur passé criminel.

CONTESTATIONS JUDICIAIRES[29]

On ne s'étonnera pas que les contestations en vertu de la *Charte* concernant la validité des lois prohibant l'usage des drogues aient jusqu'ici porté sur la marijuana, et non sur des drogues plus dures comme la cocaïne ou l'héroïne. La jurisprudence concernant le droit au cannabis à des fins médicales ayant été examinée au chapitre 13, cette section portera sur les cas où l'on revendique le droit d'utiliser des drogues à des fins non thérapeutiques (ou récréatives). Les revendications relatives à l'usage à des fins médicales ont obtenu plus de succès, mais les tribunaux prennent plus au sérieux qu'il y a quelques années les requérants prônant l'usage à des fins récréatives.

Jusqu'ici, au Canada, les tribunaux ont confirmé l'interdiction législative de l'usage non thérapeutique de la marijuana. Mais leurs motifs sont maintenant plus élaborés, nombreux et étayés. Cela traduit manifestement, du moins en partie, une évolution de la perception judiciaire de la portée de l'article 7 de la *Charte.*

Nous n'avons trouvé aucun cas de contestation de l'interdiction de la marijuana ou d'autres drogues en vertu de la *Déclaration canadienne des droits.* Cela s'explique, du moins en partie, par la façon dont les tribunaux abordent la *Déclaration des droits* en général et la clause relative à « l'application régulière de la loi » en particulier. C'est avec circonspection que les tribunaux ont appliqué la *Déclaration des droits*, qui, comme il s'agit d'une loi ordinaire, « *ne traduit pas* » selon eux « *un mandat constitutionnel clair de rendre des décisions judiciaires ayant pour effet de limiter ou de restreindre la souveraineté traditionnelle du Parlement* »[30]. De plus, le principe de « l'application régulière de la loi » se limitait, selon

---

[28] Patricia Erickson et Benedikt Fisher, *Politique canadienne sur le cannabis : conséquences de la criminalisation, réalité actuelle et possibilités d'action future,* Communication présentée dans le cadre du Symposium international sur la politique en matière de cannabis, le droit criminel et les droits de la personne à Bremen, en Allemagne, du 5 au 7 octobre 1995.

[29] La présente section est en grande partie inspirée du document intitulé *La prohibition des drogues et la Constitution*, préparé pour le Comité spécial du Sénat sur les drogues illicites par David Goetz, Division du droit et du gouvernement, Direction de la recherche parlementaire, Bibliothèque du Parlement, 1er mars 2001.

[30] R c. *Therens*, [1985] 1 R.C.S. 613, par. 639, selon le juge Le Dain.

le point de vue d'alors, à l'équité de la procédure, et le droit à la « liberté » était visiblement censé signifier uniquement la protection contre la contrainte physique.

Le premier cas de contestation en vertu de la *Charte* relativement à l'infraction de possession de narcotique illicite (en l'occurrence de la marijuana) fut l'affaire R. c. *Lepage* (8 mai 1989)[31], portée devant la Cour supérieure du Québec. Cependant, ce jugement n'a pas été publié, et nous n'avons pas pu en trouver d'exemplaire ; nous ne disposons donc pas des motifs de la décision ni des dispositions de la *Charte* qui y ont été invoquées.

La décision de la Cour suprême de la Colombie-Britannique dans l'affaire R. c. *Cholette* (1993)[32] est la première que nous ayons pu trouver qui ait trait directement à une contestation de l'interdiction de la marijuana en vertu de l'article 7 de la *Charte*. En l'espèce, l'accusé soutenait que l'interdiction enfreignait son droit à la sécurité de sa personne selon l'article 7. L'accusé avait évoqué les bienfaits qu'il retirait de l'usage de la marijuana et contesté les motifs de la décision initiale du gouvernement lorsqu'il a interdit la marijuana en 1923 (l'accusé estimait que cela traduisait un préjugé et un stéréotype antiasiatique) et le maintien de cette interdiction, affirmant que rien ne prouvait que la société subissait des torts importants à cet égard. Le juge Dorgan a rejeté l'argument de l'accusé et conclu que celui-ci n'avait pas fait la preuve que l'interdiction de la marijuana [Traduction] « *entrave de quelque manière concrète le droit d'avoir accès à un traitement médical pour des troubles représentant un danger pour la vie ou la santé de l'accusé* [...]. »[33]

Quatre mois après l'affaire *Cholette*, la Cour d'appel du Québec a dû répondre à des arguments du même genre dans l'affaire *R.* c. *Hamon* (1993).[34] Cette fois, l'accusé s'inspirait d'une conception plus large du droit à la liberté proposée par la juge Wilson dans l'affaire *Morgentaler*, faisant valoir que la décision de consommer de la marijuana était une décision personnelle. L'accusé estimait par ailleurs que, comme la marijuana ne cause pas vraiment de tort à la collectivité (ou du moins pas plus que le tabac ou l'alcool), son interdiction était arbitraire et irrationnelle et, par conséquent, contraire aux principes de justice fondamentale. Le juge Beauregard, parlant pour la Cour, était disposé à supposer qu'une interdiction pénale arbitraire serait contraire aux principes de justice fondamentale.[35] Mais le tribunal a conclu que cette interdiction n'était pas arbitraire et il a accepté le témoignage du spécialiste invité à comparaître pour le gouvernement selon lequel l'usage du cannabis avait des effets néfastes sur les utilisateurs et sur la collectivité.[36] De plus, le tribunal a rejeté la proposition que la décision du gouvernement de traiter le cannabis différemment du tabac et de l'alcool

---

[31] Bruce A. MacFarlane, Robert J. Frater et Chantal Proulx, *Drug Offences in Canada*, Aurora (Ontario), Canada Law Book, 1996 (révisé en novembre 2000) (non relié), pages 4-27.

[32] [1993] B.C.J. nº 2616.

[33] *Ibid.*, par. 9.

[34] 20 C.R.R., (2d) 181, [1993] A.Q. nº 1656.

[35] *Ibid.*, par.183 C.R.R. et par. 14, [1993] A.Q.

[36] *Ibid.*, par.183-184 C.R.R. et par. 17-20, [1993] A.Q

était injuste.[37] L'autorisation de faire appel de cette décision devant la Cour suprême du Canada fut refusée.

En 1997, dans l'affaire *R.* c. *Hunter*[38], le juge Drake de la Cour suprême de la Colombie-Britannique a répondu à une contestation de l'interdiction de la marijuana et de la psilocybine en vertu de diverses dispositions de la *Charte*. Le juge a rejeté sommairement les arguments de l'accusé selon lesquels les interdictions enfreignaient les droits garantis par l'article 7 en matière de liberté et de sécurité de la personne, déclarant simplement que [Traduction] « *les deux lois comportent des interdictions raisonnables contre certains comportements et que la portée de leur application n'est pas exagérée* » et invoquant, pour l'approuver, la décision de la Cour d'appel du Québec dans l'affaire *Hamon.*[39]

Dans les affaires antérieures relatives à des contestations de l'interdiction de la marijuana (et de la psilocybine dans l'affaire *Hunter*) en vertu de l'article 7 de la *Charte*, les tribunaux avaient rejeté ces arguments sans trop s'y attarder. Cependant, dans deux décisions de tribunaux provinciaux publiées en 2000, des arguments semblables ont fait l'objet d'une analyse plus approfondie.

La première est l'affaire *R.* c. *Malmo-Levine* (et la décision complémentaire *Regina* c. *Caine*)[40], qui a fait l'objet d'un jugement de la Cour d'appel de la Colombie-Britannique publié le 2 juin 2000. En l'espèce, une majorité de la Cour a conclu que la prohibition pénale de la simple possession de marijuana est conforme à l'article 7 de la *Charte.*

Premièrement, la Cour a décidé que le droit à la liberté garanti à l'accusé par l'article 7 était en jeu du fait que la peine prévue pour l'infraction pouvait être l'emprisonnement et qu'il n'était donc pas nécessaire de décider si l'usage personnel de marijuana à des fins récréatives était un droit garanti par ailleurs dans le cadre du droit à la « liberté ».[41]

S'exprimant au nom de la majorité, le juge Braidwood s'est ensuite attelé à la tâche de circonscrire et de définir les principes de justice fondamentale applicables en l'espèce. Après avoir pris connaissance de la jurisprudence ordinaire et de la jurisprudence constitutionnelle, de la doctrine juridique et de traités de philosophie (notamment de John Stuart Mill), et des rapports de la Commission de réforme du droit, la Cour a accepté l'argument de l'accusé, qui soutenait que les principes de justice fondamentale au sens de l'article 7 de la *Charte* comportent un précepte formulé comme « principe du préjudice », selon lequel une personne ne doit pas être emprisonnée à moins que ses activités ne risquent de causer préjudice aux autres.[42] De plus, ce principe suppose que le degré de préjudice en question ne soit [Traduction] « *ni insignifiant ni négligeable* ».[43]

---

[37] *Ibid.*, par.185 C.R.R. et par. 22-26, [1993] A.Q
[38] [1997] B.C.J. nº 1315.
[39] *Ibid.*, par. 15.
[40] [2000] B.C.J. nº 1095.
[41] *Ibid.*, par. 69.
[42] *Ibid.*, par. 134.
[43] *Ibid.*, par. 138.

Le «principe du préjudice» considéré comme principe de justice fondamentale s'inscrit dans la foulée de la prémisse avancée par la Cour d'appel du Québec dans l'affaire *Hamon* selon laquelle une interdiction arbitraire et irrationnelle est contraire à l'article 7 de la *Charte*.

Comme dans l'affaire *Hamon*, la majorité de la Cour dans l'affaire *Malmo-Levine* a conclu que l'interdiction n'était pas arbitraire. Le juge Braidwood, parlant au nom de la majorité de la Cour, a soutenu que l'interdiction pénale de possession de marijuana satisfaisait le principe du préjudice. La majorité a conclu que le Parlement avait eu des « motifs raisonnables » d'interdire la marijuana étant donné les constatations suivantes au sujet des effets de son usage sur la santé :

- Affaiblissement de la capacité à conduire, à piloter ou à faire fonctionner des machines complexes, et à cet égard les utilisateurs risquent de causer préjudice aux autres comme à eux-mêmes (quoiqu'on ne puisse pas dire que le nombre d'accidents attribuables à la consommation de marijuana est important).
- Risque pour le consommateur de devenir un utilisateur « chronique ». Environ 5 % des consommateurs de marijuana sont des utilisateurs chroniques, et il est impossible de prévoir qui est susceptible de devenir un utilisateur chronique. Si la marijuana était légalisée, le nombre de consommateurs et donc d'utilisateurs chroniques risquerait d'augmenter.
- Risques accrus pour la santé des «personnes vulnérables », par exemple les jeunes adolescents.
- Risques de coûts supplémentaires pour le système de santé et le système d'aide sociale (bien que, aux taux actuels de consommation, ces coûts seraient « négligeables » comparativement aux coûts associés à la consommation de tabac ou d'alcool).[44]

Le juge Braidwood a ensuite mis en balance les intérêts de l'État et les droits de la personne, selon le point de vue adopté par la Cour suprême du Canada dans l'affaire *Cunningham*, pour déterminer si l'interdiction pénale de la possession de marijuana constituait un «juste équilibre » entre les intérêts individuels et les intérêts collectifs. Du point de vue individuel, la Cour a évalué les effets délétères de l'emprisonnement et de l'établissement d'un casier judiciaire sur la personne et sa famille. Elle a également rappelé le manque de respect et de confiance à l'égard des lois antidrogues qu'alimente l'interdiction de possession de marijuana. Du côté des intérêts de l'État, la Cour a évalué le fait que le maintien de l'interdiction puisse servir à limiter autant que possible les préjudices causés aux utilisateurs éventuels et à la société par l'usage du cannabis, qui, [Traduction] « *si minimes soient-ils* [...] *ne sont ni insignifiants ni négligeables* ».[45] La Cour a par ailleurs fait remarquer que, dans la pratique, il y a de bonnes chances qu'une

[44] *Ibid.*, para. 142.
[45] *Ibid.*, par. 150.

personne mise en accusation pour simple possession de marijuana fasse l'objet d'une légère amende ou soit relâchée, à moins qu'il s'agisse d'un récidiviste.[46] Il n'en reste pas moins, a-t-elle ajouté, que la menace d'une peine d'emprisonnement demeure et que, quoi qu'il en soit, [Traduction] « *tous les ans, des milliers de Canadiens se voient attribuer un casier judiciaire en raison d'une activité remarquablement bénigne* ».[47]

Enfin, le juge Braidwood a fait remarquer que le résultat de l'évaluation comparative des intérêts en jeu était [Traduction] « *très serré* » et que « *il n'y avait pas clairement de gagnant* ».[48] Il a cependant rappelé que le Parlement doit faire l'objet d'une certaine déférence dans les questions relatives à l'ordre public et il est revenu à sa conclusion que, même si la menace que représente la marijuana n'est pas très grave, il n'était pas nécessaire qu'elle le soit pour que le Parlement intervienne.[49] Du point de vue des principes de justice fondamentale, il suffit d'une « appréhension raisonnée du préjudice ».[50] Comme cela a été démontré, la majorité a rejeté la contestation présentée par l'accusé en vertu de l'article 7.

Dans son opinion dissidente, le juge Prowse, tout en étant d'accord avec une grande partie de l'analyse du juge Braidwood, a estimé que l'article 7 et le principe du préjudice exigeaient un degré de dommage plus élevé que simplement non insignifiant ou non négligeable pour justifier une interdiction pénale. Comme l'accusé avait pu démontrer l'absence de preuves attestant une appréhension raisonnable de tort « grave, substantiel ou important », le juge Prowse aurait conclu que l'interdiction pénale de la simple possession de marijuana enfreignait l'article 7 de la *Charte*.[51]

Dans l'affaire R. c. *Clay*[52] (31 juillet 2000), la Cour d'appel de l'Ontario a abordé à peu près les mêmes questions que celles qui ont été traitées dans l'affaire *Malmo-Levine*. De plus, c'est un tribunal unanime de la Cour d'appel de l'Ontario qui a conclu dans le même sens que la majorité de la Cour d'appel de la Colombie-Britannique le mois précédent.

Dans l'affaire *Clay*, le juge Rosenberg, parlant pour la Cour, a accepté le « principe du préjudice » explicité par le juge Braidwood dans l'affaire *Malmo-Levine*.[53] Il a entre autres rappelé que la notion d'un « principe du préjudice » contenue à l'article 7 était conforme à la déclaration du juge Sopinka dans l'affaire *Rodriguez*, énonçant que « *lorsque la restriction du droit en cause ne fait que peu ou rien pour promouvoir l'intérêt de l'État (quel qu'il puisse être), il* [...] *semble qu'une violation de la justice fondamentale sera établie puisque la restriction du droit du particulier n'aura servi aucune fin valable* ».[54]

---

[46] *Ibid.*, par. 153.
[47] *Ibid.*, par. 155.
[48] *Ibid.*, par. 155 et 156.
[49] *Ibid.*, par. 156 et 158.
[50] *Ibid.*, par. 158.
[51] *Ibid.*, par. 165 et 167-186.
[52] (2000), 49 O.R. (3d) 577.
[53] *Ibid.*, par. 28-31.
[54] *Ibid.*, par. 31.

De plus, en appliquant le «principe du préjudice » à l'interdiction pénale de la possession de marijuana, la Cour est parvenue à la même conclusion que la majorité dans l'affaire *Malmo-Levine* : comme il existe des preuves que le tort causé par la marijuana n'est ni négligeable ni insignifiant, le Parlement a des motifs raisonnables d'intervenir comme il l'a fait, et l'interdiction de la marijuana est donc conforme aux principes de justice fondamentale au sens de l'article 7.[55]

Dans l'affaire *Clay*, le juge Rosenberg, a fait remarquer que, si les raisons initiales d'inclure la marijuana parmi les narcotiques prohibés reflétaient peut-être un certain « *racisme* » et des « *craintes irrationnelles et sans fondement* », l'objectif, valable celui-là, d'éviter des préjudices aux Canadiens demeurait constant.[56] La Cour a également rejeté (du point de vue de l'analyse constitutionnelle) la pertinence des arguments et des éléments de preuve selon lesquels des substances licites, comme l'alcool et le tabac, causent des dommages plus grands que la marijuana : [Traduction] « *le fait que le Parlement n'ait pas pu ou pas voulu interdire l'usage d'autres substances plus dangereuses n'exclut pas son intervention à l'égard de la marijuana, pourvu qu'il ait des motifs raisonnables de le faire* ».[57] La Cour a conclu que tel était le cas et elle a confirmé l'interdiction de la possession de marijuana, sauf à des fins médicales (lequel cas a été analysé par la Cour dans l'affaire parallèle *R.* c. *Parker*, dont nous avons parlé au chapitre 13).[58]

Comme dans l'affaire *Malmo-Levine*, la Cour a conclu dans l'affaire *Clay* que l'article 7 de la *Charte* avait été évoqué en raison de la possibilité d'emprisonnement, qui renvoyait au droit à la liberté de l'accusé. La Cour a cependant été plus loin dans l'affaire *Clay*, où elle a répondu à l'argument que l'usage personnel en soi de marijuana était protégé en tant qu'aspect du droit à la liberté et/ou à la sécurité de la personne étant donné la conception élargie de ces droits par la Cour suprême du Canada dans les arrêts *B. (R.)* c. *Children's Aid Society of Metropolitan Toronto*, *Nouveau-Brunswick (ministre de la Santé et des* services *communautaires)* c. *G. (J.)* et *Rodriguez* (analysés plus haut). La Cour a conclu que l'usage personnel de la marijuana (en dehors de son usage médicinal effectif) ne mettait pas en jeu [Traduction] «*l'aspect plus large du droit à la liberté* » qui protège la liberté de prendre des décisions «*d'importance fondamentale pour la personne* ».[59] Il n'entrait pas non plus dans la sphère de l'autonomie personnelle, qui englobe le droit de [Traduction] «*faire des choix concernant son propre corps* » et le droit [Traduction] « *à la dignité humaine fondamentale* » en tant qu'aspects du droit à la sécurité de la personne.[60]

La Cour suprême est actuellement saisie des affaires *Malmo-Levine*, *Caine* et *Clay*. La Cour sera appelée à décider si l'article 7 de la Charte contient le «principe du préjudice » et à répondre à la question connexe, soit le seuil de préjudice acceptable :

---

[55] *Ibid.*, par. 34 et 37.
[56] *Ibid.*, par. 34.
[57] *Ibid.*, par. 36.
[58] *Ibid.*, par. 37 et 38.
[59] *Ibid.*, par. 13.
[60] *Ibid.*, par. 14-18.

est-il suffisant que le préjudice ne soit « ni insignifiant ni négligeable » ou faut-il qu'il y ait appréhension raisonnable de préjudice grave, considérable ou important ?

CONCLUSIONS

Conclusions du chapitre 15

- **Les coûts reliés aux poursuites pour infractions liées aux drogues en 2000-2001 s'élevaient à 57 millions $ dont environ 5 millions $ correspondaient à des poursuites pour infractions de possession de cannabis, ou environ 10 % du budget total.**
- **En 1999, on évalue que les tribunaux de justice pénale canadiens ont traité 34 000 affaires liées aux drogues nécessitant plus de 400 000 comparutions.**
- **Les initiatives des tribunaux de traitement de la toxicomanie semblent encourageantes mais il faudra attendre les résultats des évaluations pour s'assurer que ces programmes sont efficaces.**
- **Les données relatives à la décision et à la détermination de sanction pour ce qui est des infractions liées aux drogues, sont faibles et il existe un besoin urgent de corriger cette situation.**
- **Le Service correctionnel du Canada dépense un montant évalué à 169 millions $ pour faire face aux drogues illicites au moyen de l'incarcération, de programmes de lutte contre la toxicomanie, de programmes de traitement et de mesures de sécurité ; les dépenses pour les programmes de lutte contre la toxicomanie sont relativement peu élevées compte tenu du nombre de détenus qui ont de tels problèmes.**
- **Une condamnation criminelle liée aux drogues peut causer un impact négatif sur la situation financière d'une personne, sur ses perspectives d'emploi et restreindre sa capacité à voyager à l'étranger. De plus, cela peut constituer un facteur important lors d'une future implication avec le système de justice pénale.**
- **Les cours d'appel provinciales ont jusqu'à maintenant maintenu la constitutionnalité de l'interdiction du cannabis. Elles ont observé que les dommages causés par la consommation de marijuana ne sont ni insignifiants ni négligeables, justifiant ainsi le Parlement d'agir comme il l'a fait, et ont donc conclu que l'interdiction de la marijuana est par conséquent en accord avec les principes de justice fondamentale de l'article 7 de la Charte. Ces**

	décisions ont fait l'objet d'un appel et la Cour Suprême du Canada décidera bientôt si l'interdiction du cannabis à des fins non médicales est constitutionnelle.

CHAPITRE 16

PRATIQUES PRÉVENTIVES

La prévention est au cœur des approches de santé publique de même qu'elle est de plus en plus intégrée à la panoplie des actions de lutte à la criminalité, notamment la criminalité reliée aux usages excessifs de substances psychoactives. Conçue, au moins théoriquement, sous l'angle de la santé publique, une politique sur les drogues illicites devrait donc appeler une stratégie de prévention forte.

Rien pourtant n'est plus mouvant, flou, imprécis, sinon controversé, que la prévention. Les mesures d'application de la loi sont claires : elles accordent des pouvoirs aux policiers et donnent des balises aux tribunaux pour le traitement judiciaire des personnes trouvées en contravention des dispositions de la loi. Les mesures correctionnelles sont elles aussi claires : elles mettent en oeuvre les sentences décidées par les tribunaux. Déjà, les mesures de traitement des personnes ayant des consommations à problèmes sont plus vagues, tous ne s'entendant pas sur ce qu'est une mesure de traitement, quand elle commence et surtout quand elle se termine. En matière de prévention, les auteurs distinguent entre prévention primaire, secondaire et tertiaire ; prévention par le développement social et prévention situationnelle ; prévention universelle, spécifique et indiquée ; prévention de l'usage, des conduites à risque et de l'abus. Ils ne s'accordent cependant ni sur les contenus spécifiques de chaque domaine ni sur ceux qu'il conviendrait de privilégier en fonction des orientations de politiques publiques.

Lorsqu'il est question de drogues illicites, le contexte juridique et politique rend la question de la prévention encore plus difficile à clarifier, et les actions à définir. En matière d'alcool, les politiques et les actions qui en découlent visent à prévenir des conduites à risque définies notamment la consommation excessive, la conduite sous l'influence, et les comportements afférents à la consommation abusive tels la violence intra familiale. L'alcool peut être, dans certaines circonstances, sous certaines formes d'utilisation, une substance «dangereuse » ; ce sont des circonstances que l'on voudra prévenir, en repérer les indicateurs pour éviter que la conduite à risque ne devienne conduite excessive, voire maladive. Il est possible de faire ces distinctions et ne pas se préoccuper de l'usage en soi parce que la consommation d'alcool est légale. En matière de drogues illicites le contexte juridique national et les interprétations des politiques internationales (voir le chapitre 19 sur ce dernier point), font en sorte que, définies comme produits dangereux *a priori*, elles ne doivent pas être consommées. Et que tout

usage est déjà un abus. Le glossaire publié par l'Office des Nations Unies pour le contrôle des drogues et la prévention du crime écrit en effet que :

> [Traduction] *« Dans le contexte du contrôle international des drogues, l'abus de drogues constitue* **l'usage** *de toute substance sous contrôle international à d'autres fins que pour des raisons médicales et scientifiques (…). »*[1] *(Nous soulignons)*

Si usage est abus, si l'acteur de prévention ne peut recourir à des distinctions qui lui sont pourtant essentielles pour définir les objectifs et contenus d'une mesure de prévention, comment, dans ce contexte, espérer établir des actions de prévention qui réussissent ?

Le contexte international ne laisse pas de créer des surprises. Ainsi, dans son rapport pour 1997, l'Organe international de contrôle des stupéfiants, qui a pour mission de vérifier l'application des conventions internationales par les pays signataires, propose – comme à chaque année d'ailleurs – un commentaire, celui-ci sur la prévention. Regrettant que l'environnement social fasse la promotion des drogues, le rapport note :

> *« Prévenir l'abus des drogues devient une entreprise de plus en plus difficile, ne serait-ce, en partie, qu'en raison de la prolifération de messages faisant l'apologie des drogues. Nombre de ces messages tendent pour ainsi dire à inciter ou à amener autrui à faire usage et à abuser des drogues ; c'est pourquoi il y a lieu de renforcer l'action préventive actuellement menée et de concevoir et de prendre des initiatives novatrices dans le domaine de la prévention.*
> *(…)*
> *Certes, il ne sera probablement jamais possible d'éliminer toute forme d'expérimentation et d'abus des drogues, mais il ne faudrait pas pour autant abandonner l'objectif ultime de tout effort de prévention, à savoir une société exempte de drogue. »*[2]

Parmi les facteurs propices à cet environnement « favorable » à l'usage et à l'abus de drogues, le rapport cite la culture populaire (chansons, films, etc.), les médias, l'Internet, la promotion des produits du chanvre indien et les campagnes politiques. Il fait des raccourcis pour le moins étonnants entre les prises de position sur la libéralisation des politiques sur les drogues et la « promotion » de leur usage, et laisse entrevoir une forme que nous qualifierions d'inquiétante de la prévention :

> *« Le goût du sensationnel, le désir de provoquer et la nécessité d'avoir la faveur du public peuvent également justifier la diffusion, par plusieurs télévisions de certains pays d'Europe occidentale, de plus en plus de programmes en faveur d'une réforme des lois sur les drogues, voire de la légalisation pure et simple*

---

1 UNDCP (2000) *Demand Reduction. A Glossary of Terms.* Vienne : auteur, page 22.

2 Organe international des stupéfiants (1997) « Comment prévenir l'abus de drogues dans un environnement propice à la promotion des drogues illicites. » *Rapport annuel de l'Organe international de contrôle des stupéfiants pour 1997.* Vienne : OICS, paragraphes 2 et 4.

des drogues, notamment du cannabis, au lieu d'émissions qui feraient ressortir les conséquences d'une telle politique et les méfaits qui en découleraient. »

« Il est possible d'empêcher les médias destinés au grand public, comme la presse, la radio, le cinéma et la télévision, de présenter des images faisant l'apologie des drogues. (...) Les gouvernements de ces pays devront peut-être se demander si la liberté d'accès à ces informations et leur propagation sans limites ne sont pas préjudiciables au bien-être et à la santé des populations. »

« Au cours de campagnes électorales, l'on a vu des candidats à la députation prôner la légalisation des drogues. (...) D'autres campagnes visaient à réformer les lois, telle celles menées avec succès en Arizona et en Californie en vue de l'usage « médical » du cannabis (...). (...) Il faut contrer cette propagande à l'aide d'arguments rationnels et énoncer avec force les multiples problèmes que pourrait entraîner la dépénalisation des drogues et que ne manquerait pas de faire surgir leur légalisation, en particulier sur le plan de la santé et de l'économie. (...) L'Organe constate avec regret que (...) les gouvernements des États parties à la Convention de 1988 soient tenus de conférer le caractère d'infraction pénale au fait d'inciter ou d'amener publiquement autrui à consommer des drogues, soit il n'en a rien été soit la loi adoptée pour ce faire n'a pas été appliquées. (...) »[3]

Si la critique des politiques publiques et la demande politique de révision passe pour une apologie des drogues, si la prévention consiste à museler les opposants qui ont des raisons légitimes – même si nous ne sommes pas toujours en accord les uns avec les autres – de critiquer les politiques actuelles, il faut se demander alors où commence et où arrête la « prévention ».

Bien sûr, comme ce chapitre le démontrera, de nombreux programmes de prévention existent qui ne visent pas uniquement, ni même de manière privilégiée, la prévention de tout usage mais ciblent spécifiquement les conduites à risque. L'approche de réduction des méfaits par exemple, en plus d'être une stratégie globale sur les substances psychoactives, est aussi une approche préventive en ce qu'elle vise à réduire les risques associés aux drogues et à leur contrôle sans par ailleurs demander l'abstention. Mais elle fait l'objet de multiples controverses et de critiques précisément parce qu'elle accepte comme prémisse la réalité sociale de l'usage des drogues.

L'application de la loi constitue-t-elle une mesure préventive ? Plusieurs praticiens, et pas seulement des policiers, répondraient sûrement par l'affirmative et ils auraient raison puisque la présence du policier ou des modèles de police communautaire, ont un certain effet préventif. Mais dans le contexte actuel, ces approches visent à dissuader l'usage, non à informer et éduquer sur les conduites à risque. Et nous avons vu au chapitre 14 que leur efficacité est extrêmement réduite. Les sentences et parmi elles la privation de liberté sont-elles des mesures préventives ? Sûrement, au moins pour le temps où le contrevenant est placé sous surveillance ou détenu (encore que les drogues circulent en prison). Mais d'une part nous avons vu que leur effet dissuasif sur l'usage est à peu près inexistant et d'autre part on doit se

---

3 *Ibid.*, paragraphes 18 et 21 et 25 et 27.

demander s'il n'y a pas là confusion des genres, dans la mesure où l'intervention du système de justice témoigne déjà d'un échec des mesures de prévention. L'éducation à la citoyenneté, à la santé et au respect de soi et des autres n'est-elle pas une mesure préventive ? Assurément, mais comme le sont aussi toutes les mesures d'équité et de justice sociale, de réduction des inégalités, ou de pacification de nos relations avec les Peuples Autochtones. Si tout est prévention, quel est donc le domaine de la prévention ?

Aborder la question de la prévention c'est réfléchir en même temps sur les politiques qui gouvernent les drogues illicites. C'est particulièrement vrai en matière de cannabis. Nous verrons plus loin que l'un des principes clés de la prévention est de transmettre un message crédible. En matière de tabac, le message que fumer est une cause de cancer du poumon et de maladies cardiovasculaires est crédible au moins en ce qu'il repose sur une vaste série d'études épidémiologiques qui ont établi l'association statistique forte entre la cause et l'effet. La même chose est vraie pour l'alcool au volant ou pour le port de la ceinture de sécurité. En matière de cannabis, comme l'ont démontré les chapitres 6, 7 et 8 de notre rapport, les risques associés au cannabis sont loin d'avoir été établis aussi clairement, et au contraire, le poids de la preuve penche plutôt pour une dangerosité moins élevée que la vaste majorité des autres substances psychoactives. En fait, contrairement à ce que plusieurs nous ont dit, le cannabis n'est pas illégal parce que dangereux, et l'histoire de la législation nationale aussi bien que des conventions internationales le démontre bien.

Toujours selon UNDCP :

> [Traduction] *« La prévention au sens large est une intervention qui a pour but de modifier les déterminants sociaux et environnementaux de l'abus de drogues et d'alcool, incluant décourager l'initiation de l'usage de drogues et en prévenir la progression vers un usage plus fréquent ou régulier parmi la population à risque. »*[4]

Notons quelques clefs de lecture. Pour les drogues *et* l'alcool il faut prévenir les abus. Mais pour les drogues *seulement* il faut décourager l'initiation parce que l'initiation mène à une progression vers plus de consommation. Pourtant, lorsqu'il s'agit de cannabis, les données de recherche ne permettent pas d'appuyer cette distinction. En fait, l'usage d'alcool – et avant l'alcool, de tabac – est bien plus susceptible que le cannabis de mener à un usage plus fréquent, voire à risque ; alcool et tabac sont au moins autant que le cannabis des drogues d'introduction pour d'autres drogues illicites. Mais l'alcool, comme le tabac, sont légaux, le cannabis illégal.

Discuter de prévention c'est aussi parler des limites de l'intervention de l'état et de la vision qu'on se fait de l'acteur humain. Jusqu'où aller pour identifier les groupes à risque sans stigmatiser davantage des populations qui sont déjà vulnérables ? Dans

[4] *Ibid.*, page 58.

quelle mesure penser que l'acteur humain est un être rationnel qui agit conformément à son meilleur intérêt pour autant qu'on lui donne la bonne information ?

Enfin, dans le contexte canadien parler de prévention impose une observation d'ordre constitutionnel : si et dans la mesure où les actions de prévention tombent sous le champ de la santé et de l'éducation, elles sont donc principalement – pour la santé – et uniquement – pour l'éducation – du ressort des provinces. Comme nous l'avons vu au chapitre 12 sur l'historique de la législation nationale en matière de drogues illicites, il n'était pas accidentel que la loi sur les stupéfiants soit une loi pénale : c'était le seul moyen pour le gouvernement fédéral de légiférer dans ce domaine à l'intérieur de son champ de compétences constitutionnelles. Le champ d'action du fédéral en matière de prévention de l'usage de cannabis est donc au mieux restreint, au pire inexistant proprio motu.

Ce chapitre sur la prévention commence sur une affirmation qui n'étonnera aucun des spécialistes des secteurs de la santé et de la justice : autant les discours sur la prévention sont forts, autant les ressources qu'on y consacre sont maigres et les actions menées faibles. La section suivante pose la question: quelle prévention ? Nous y examinons les connaissances disponibles sur les facteurs qui sous-tendent les actions de prévention et sur l'efficacité de certains types d'actions de prévention, portant une attention particulière à l'un des fleurons de la lutte antidrogues, le programme DARE. La troisième section s'intéresse à l'approche de réduction des méfaits comme approche de prévention. Comme pour les autres chapitres, nos conclusions prennent la forme de constats susceptibles d'orienter la suite.

DES ACTIONS QUI NE SONT PAS À LA HAUTEUR DES DISCOURS

Lors du lancement de la Stratégie canadienne antidrogue en 1987, le Gouvernement reconnaissait que la majorité des actions fédérales avait porté sur la réduction de l'offre et qu'il fallait augmenter l'effort de prévention. Des 210 millions $ initialement alloués à la première stratégie quinquennale, pas moins de 32 % devaient être investis en actions de prévention. La deuxième phase de la stratégie, de 1992 à 1997, portait le budget global à 270 millions $, reconduisant sensiblement la même ventilation des fonds.

En 1994, le Gouvernement du Canada a implanté la Stratégie nationale sur la sécurité communautaire et la prévention du crime et créé le Conseil national de la prévention du crime du Canada, devenu depuis le Centre national de prévention du crime (ministère de la Justice). Au lancement de la Phase II de la stratégie en 1998, le financement était de 32 millions $ par année, et il a été porté, en 2001, à plus de 65 millions $. Cette stratégie :

« (...) vise à réduire la criminalité et la victimisation en agissant sur les causes mêmes de la criminalité et de la victimisation à l'aide d'une approche axée sur le développement social. La prévention du crime par le développement social (PCDS) est une approche proactive à long terme. Elle s'attaque aux facteurs personnels, sociaux et économiques qui amènent certaines personnes à prendre la voie du crime ou à devenir victime du crime. La Stratégie nationale *soutient des projets qui visent les facteurs de risque qui affectent la vie des gens tels que les mauvais traitements, la violence, l'incompétence parentale, l'alcoolisme et la toxicomanie. »* [5]

Qu'en est-il dans les faits ? Les intervenants s'entendent probablement unanimement pour dire que la prévention est nécessaire. Mais ils s'entendent tout aussi unanimement pour dire que les actions menées ne sont pas à la hauteur des discours. Ou pour le dire autrement, tout le monde parle de prévention mais il s'en fait peu. Les observations qu'on nous a faites portent sur cinq ensembles de considérations : (1) on ne fait pas assez de prévention ; (2) on ne fait pas une prévention suffisamment ciblée ; (3) on ne fait pas suffisamment l'évaluation des actions de prévention ; (4) les messages de prévention et les discours sociaux sont en contradiction ; et (5) il existe des pratiques modèles et une connaissance de mesures de prévention réussies qu'il faudrait disséminer plus largement.

On ne fait pas suffisamment de prévention

Pour de nombreux intervenants du monde associatif, du monde policier, ou des organisations gouvernementales de lutte à la toxicomanie, il est clair qu'on ne fait pas suffisamment de prévention. Cette situation se mesure tant en terme des montants investis que des compressions dans les personnels de prévention.

« Essayez de vous souvenir du dernier message de prévention antidrogues que vous avez vu à la télévision. Un que la plupart d'entre nous reconnaîtraient probablement est celui de l'œuf poêlé représentant l'effet des drogues sur le cerveau humain. Il s'agit toutefois d'une publicité américaine. Je ne me souviens pas d'avoir vu dernièrement une annonce antidrogues canadienne à la télévision. D'autres documents à caractère préventif ont été produits dans bien d'autres domaines au Canada. Il suffit de penser à la campagne antitabac et à la campagne concernant la prévention du cancer du sein. Par contre, dans le domaine de la lutte antidrogues, les documents à caractère préventif sont très peu nombreux. Nous ne voulons pas davantage d'argent pour les services policiers et pour les arrestations. Nous trouvons que nous disposons de fonds suffisants dans ce domaine. Nous pensons cependant que non seulement la prévention mais aussi la sensibilisation aux drogues sont des outils essentiels qui font une différence. (...) Nous pensons que la police a un rôle à jouer en matière de prévention et de sensibilisation comme en matière d'application des lois. Nous avons établi d'excellents partenariats avec des enseignants, des parents et des groupes communautaires. Les services de police communautaire n'existent que depuis une dizaine d'années. (...) Un des problèmes qui se posent est que plusieurs de nos programmes datent. On consacre très peu d'efforts à la prévention. Je ne tiens pas à citer des montants précis. Cependant, d'après un document publié il y a un an, le gouvernement américain investit une douzaine de dollars par

---

5 Centre national de prévention du crime, énoncé d'objectifs, en ligne à www.crime-prevention.org

habitant dans la prévention et la sensibilisation. Au Canada, on y consacre moins de 1 $. Je crois que c'est environ 20 ou 30 cents. »[6]

« Depuis 1988 et 1989, date de la fin de la campagne Drogues pas besoin *on n'a plus mis en œuvre de campagnes de lutte fédérale contre les drogues ou de campagnes provinciales dans le cas de la Colombie-Britannique. (...) Lorsqu'on a cessé de mettre l'accent sur la prévention, et à l'expiration de la Stratégie canadienne antidrogue, j'ai constaté que de nombreuses coalitions et de nombreux groupes de travail communautaires de lutte contre les drogues ont cessé leurs activités faute de fonds. J'ai constaté ce phénomène à Naskup, à Penticton, le long de la Sunshine Coast, à Whistler et dans de nombreux autres endroits à mesure que les intervenants sur le terrain devaient cesser leurs actions parce que toute l'attention du pays était maintenant tournée vers la santé des populations. On a cessé de s'intéresser à la prévention et de financer des initiatives dans ce domaine pendant qu'on commençait à parler du chanvre, de la marijuana médicinale et de questions connexes. (...) Compte tenu du fait que cette situation existe depuis des années, comment s'étonner que la consommation du cannabis ait augmenté. Comment s'en étonner en effet quand on ajoute à cela l'imposition de sentences plus clémentes dans le cas des crimes liés au trafic des drogues et à l'énorme augmentation dans la disponibilité du cannabis. »*[7]

« Troisième constat : les efforts consentis en prévention de la toxicomanie sont nettement insuffisants. Il est question ici à la fois d'efforts budgétaires (accroître, dans les différents secteurs d'intervention, les sommes allouées à la prévention), d'efforts de coordination (encadrer davantage les pratiques dans ce champ d'activité) et d'efforts de recherche (établir des paramètres clairs d'évaluation des programmes, statuer sur l'efficacité des programmes existants, faire connaître les stratégies gagnantes). Une intensification des efforts en prévention des toxicomanies est particulièrement souhaitée dans les secteurs suivants :

- *A l'école (dès le deuxième cycle du primaire) et dans les autres milieux de vie des jeunes (ex. : dans la rue, dans les parcs, dans les maisons de jeunes, dans les centres jeunesse) ;*
- *Dans les milieux de travail ;*
- *Dans les services de première ligne du réseau de la santé et des services sociaux.»*[8]

« Nous avions élaboré un excellent programme canadien en Nouvelle-Écosse en collaboration avec la Nova Scotia Addiction Foundation, appelé Contribution de la police à l'éducation communautaire. Nous faisions partie, avec un pharmacien, une infirmière et quelques athlètes, d'un groupe qui allait dans les écoles pour parler aux élèves de l'influence des camarades, des raisons pour lesquelles certains se sentent obligés de consommer des drogues, du vol et de différents sujets touchant la morale ainsi que d'autres liés à la consommation des drogues. Malheureusement, suite aux compressions budgétaires, les

[6] M. Barry King, chef du Service de police de Brockville, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 11 mars 2002, fascicule 14, pages 82-83.

[7] Dr Colin R. Mangham, directeur, Prevention Source B.C., témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 17 septembre 2001, fascicule 6, pages 74-75.

[8] Comité permanent de lutte à la toxicomanie (2000) *Consultation 2000. La toxicomanie au Québec : Cap sur une stratégie nationale.* Québec : auteur, page 13.

programmes ont été coupés. Les crédits pour les évaluations, pour l'extension, ou pour l'amélioration du programme n'étaient pas disponibles. »[9]

« Dans les années 70 et 80, les efforts de prévention permanents dans la collectivité recevaient beaucoup de soutien. Malheureusement, les gouvernements fédéral et provinciaux ont supprimé une grande partie de leur financement dans les années 90, ce qui a entraîné une augmentation correspondante de la consommation de drogues. Au cours de la même période, des efforts de prévention visant plusieurs éléments tels que le tabac, les ceintures de sécurité, les moyens de protection contre l'incendie, la condition physique et la santé dentaire, pour ne nommer que ceux là, ont permis de faire d'énormes progrès. »[10]

En fait, la prévention des problématiques socio-sanitaires reste souvent le parent pauvre des pratiques. Qu'il s'agisse de santé ou de justice, la réalité montre que les crédits sont encore très largement axés sur la cure, sur l'intervention après l'apparition du problème. C'est vrai pour les questions de santé en général comme pour les questions spécifiques aux drogues illicites.

Selon l'étude de Single et coll.,[11] les coûts directs et indirects de l'abus de drogues illicites en 1996 étaient d'environ 1,5 milliard $. De ce montant, 400 millions $ étaient consacrés à l'application de la loi (police, douanes, tribunaux, services correctionnels, etc.), et environ 35 millions $ à la prévention, c'est-à-dire environ 2 % des coûts totaux comparativement à plus de 25 % pour la répression. Pour le traduire d'une autre manière, les coûts des drogues illicites sont d'environ 48 $ par habitant, les coûts de la répression en cette matière d'environ 12 $ et ceux de la prévention d'environ 1 $.[12] **Nous sommes d'avis, avec les intervenants, que les dépenses en prévention sont nettement insuffisantes.**

La prévention est insuffisamment ciblée

Prévenir l'usage de cannabis appelle probablement d'autres moyens que celui de l'héroïne ou de l'ecstasy. De la même manière, la prévention auprès des jeunes en milieu scolaire ne sera pas faite de la même manière que celle en milieu de travail ou auprès des jeunes de rue, celle auprès des jeunes Autochtones de la même manière que celle auprès des jeunes blancs. Nous verrons d'ailleurs à la section suivante que les

---

9 Surintendant principal R.G. Lesser, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 29 octobre 2002, fascicule 8, page 14.

10 M. Art Steinman, Directeur général, *Alcohol-Drug Education Service*, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 7 novembre 2002, fascicule 10, page 86.

11 Single, E., et coll., (1996) *The Costs of Substance Abuse in Canada.* Ottawa : Centre canadien de lutte contre l'alcoolisme et les toxicomanies.

12 Ces chiffres ne tiennent pas compte des budgets consentis à la prévention reliée à la toxicomanie par la Stratégie nationale de prévention du crime qui a été véritablement mise en œuvre à compter de 1998.

facteurs de risque et les facteurs de protection ne sont pas les mêmes pour tous les groupes sociaux.

Pourtant, les intervenants soulignent que les messages de prévention et leur mode de livraison manquent souvent de précision. Il s'agit, soit de messages à caractère universel dont il est difficile de mesurer l'efficacité réelle, soit de messages spécifiques à des groupes sociaux mais qui ne sont pas nécessairement adaptés à la réalité des personnes visées.

> *« On souligne particulièrement les manques au niveau de la prévention secondaire. Les programmes s'adressant plus spécifiquement aux groupes à risque sont insuffisants. Le dépistage est mal assuré là où une intervention précoce pourrait faire toute la différence en vue de prévenir l'aggravation des problèmes, et ce constat ne s'applique pas seulement aux jeunes, mais à des clientèles de tous âges. Il y a actuellement un manque de cohérence dans les messages véhiculés et dans les actions entreprises. Il y a un manque de stabilité des programmes. On accuse même des reculs importants dans certains secteurs (ex. : disparition progressive des éducateurs en prévention des toxicomanies). »* [13]

> *« Les mêmes mesures de prévention ne peuvent pas s'appliquer à tous. Il faut des approches destinées à la population en général, mais également des activités plus ciblées, s'adressant à un groupe à risque particulier. Bien entendu, la prévention est proactive. Elle est extrêmement rentable : avec le coût d'un centre de traitement, on peut financer des initiatives de prévention qui toucheront des centaines et peut-être des milliers de jeunes. »* [14]

Cibler la prévention oblige à clarifier les objectifs poursuivis : vise-t-on à prévenir l'usage, les conduites à risque, l'abus ? Les mesures de prévention choisies seront fondamentalement différentes selon le choix d'objectifs poursuivis. C'est ce que souligne un document récent produit pour Santé Canada sur les meilleures pratiques de prévention :

> *« Il faut se fixer des objectifs clairs et réalistes, qui feront un lien logique entre les activités du programme et les problèmes et les facteurs déterminés et qui guideront la mise en oeuvre du programme. Des objectifs clairs et mesurables faciliteront l'évaluation et permettront de déterminer si le programme a vraiment atteint ses objectifs. Les objectifs varieront selon la communauté et les circonstances. Toutefois, l'âge du début de la consommation et le moment où l'usage de différentes substances devient problématique sont des données essentielles. (...) Par conséquent, pour les jeunes qui ne sont pas encore des consommateurs (et qui ne pensent même pas à consommer) l'objectif du programme sera la prévention primaire. Pour ce qui est de programmes qui s'adressent à une population en majorité composée de jeunes qui ont commencé à consommer et continuent de le faire, l'objectif sera plutôt la prévention secondaire ou la réduction des*

---

[13] Comité permanent de lutte à la toxicomanie, *op. cit.*, page 14.

[14] M. Art Steinman, Directeur général, *Alcohol-Drug Education Service*, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 7 novembre 2002, fascicule 10, page 85.

méfaits. Chacun de ces objectifs mène logiquement à des activités et des messages spécifiques (le recours à des approches plus intensives auprès des consommateurs ou ceux qui s'apprêtent à le devenir. »[15]

De plus, en matière de prévention, il se dégage une impression qu'on peut faire un peu tout et n'importe quoi du moment qu'on tient un discours antidrogues. Or, comme le démontrera la section suivante, les actions de prévention doivent cibler avec précision des facteurs de risque connus et des facteurs de protection. Et puisqu'il existe de multiples facteurs de risque, elles doivent être globales et impliquer la communauté.

On ne fait pas suffisamment l'évaluation des mesures de prévention

Si on ne fait pas suffisamment de prévention, c'est aussi parce qu'on ne prend pas le temps, ni ne consacre les ressources, pour évaluer les programmes et en démontrer l'efficacité. On dit souvent qu'une once de prévention vaut mieux qu'une livre de traitement. D'autres soutiennent dans le même ordre d'idée qu'un dollar investi en prévention en épargne cinq plus tard. C'est probablement vrai dans une certaine mesure. Mais le démontrer est autre chose.

Les études d'évaluation sont difficiles à mener. Pour être crédibles, elles requièrent souvent un appareillage méthodologique complexe. Elles sont aussi coûteuses. Et surtout, elles ne peuvent pas – ou du moins ne devraient pas – être faites à la va-vite pour répondre au temps du politique ; pour savoir par exemple si un programme de prévention de l'usage de drogues auprès des jeunes est efficace, il faut prévoir un suivi des « diplômés » sur une année au moins après la fin de leur formation, normalement au moins trois. Le Canada n'a pas une pratique de la recherche évaluative et, comme nous l'avons vu pour la Stratégie nationale antidrogue, ne s'était ni fixé des objectifs clairs ni donné les moyens d'en faire l'évaluation.

Il résulte entre autres de cette situation que le domaine de la prévention, secteur mou s'il en est, fera les frais de la moindre coupure budgétaire.

« Un des problèmes majeurs est que nos programmes ne sont pas assortis d'un mécanisme d'évaluation. Chaque fois que nous avions l'occasion de mettre en œuvre de nouveaux programmes, c'était fait à la hâte et le travail était bâclé. On disposait de très peu de fonds. On se contentait de faire des essais pour voir si c'était efficace. Nous avons appris que si l'on voulait intervenir, il fallait le faire de façon adéquate. Il faudrait établir de nouveaux programmes comportant un mécanisme d'évaluation afin de savoir s'ils permettraient d'atteindre les objectifs de façon satisfaisante et en temps opportun. Autrement dit, il faudrait tenir compte du message, de son destinataire et de l'efficacité. »[16]

---

15 Roberts, G. et coll., (2001) *Prévention des problèmes attribuables à la consommation d'alcool et d'autres drogues chez les jeunes. Un compendium des meilleures pratiques.* Bureau de la Stratégie canadienne antidrogue, Santé Canada. Ottawa : Approvisionnement et services, pages 33-34.

16 M. Barry King, chef du Service de police de Brockville, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 11 mars 2002, fascicule 14, page 83.

Le Comité est d'avis que toute stratégie canadienne future sur les drogues **devra prévoir des mécanismes et des ressources pour l'évaluation des diverses composantes et notamment pour l'évaluation des actions de prévention.**

Les messages sociaux contredisent les messages de prévention

Pour un certain nombre d'observateurs, le fait que les messages sociaux entourant le cannabis soient devenus plus tolérants au cours des dernières années a contribué à l'augmentation de la consommation chez les jeunes et à contredire les discours de prévention.

> *« Il importe aussi d'attacher de l'importance à la façon dont la consommation de drogue est perçue. L'existence de sanctions juridiques influence davantage sur l'acceptabilité d'une substance que sur sa disponibilité. L'acceptabilité sociale des drogues diminue lorsque leur consommation donne lieu à des sanctions ce qui à son tour réduit la consommation. L'acceptabilité d'une substance est liée au risque qu'elle présente ainsi qu'à la mesure dans laquelle elle est acceptée par la société. Voilà les deux outils dont nous disposons pour limiter la consommation des drogues. »*[17]

> *« D'après l'étude intitulée Monitoring the Future effectuée par l'Université du Michigan en 1996, à notre époque, les adolescents ont moins tendance à considérer que la consommation de drogues est nocive et présente des risques et ils sont plus enclins à croire qu'elle est répandue et tolérée ; en outre, ils subissent davantage de pressions que jamais au cours des dix dernières années les incitant à essayer des drogues illicites. (...) On peut en déduire que ce sont des facteurs qui ont une influence sur une augmentation ou une diminution du taux de consommation des drogues. La légalisation de drogues illicites ne pourrait qu'atténuer davantage ces perceptions. Elle indiquerait à nos enfants que les adultes pensent que l'on peut faire une utilisation judicieuse des drogues. Elle porterait à croire que les risques sont moins élevés et que les drogues sont plus acceptables. (...) Un autre facteur est l'influence qu'exercent les médias et le pouvoir de la communication. La description dans les médias de personnes qui fument de la marijuana dans des clubs de cannabis porte les enfants à croire que la consommation de drogues peut être intéressante. Dans un tel contexte, il est très difficile, voire impossible de convaincre les enfants que la prise de drogues est nocive. Une plus grande accessibilité et une plus forte consommation accentueront les problèmes de criminalité. Une consommation accrue a de terribles conséquences pour les citoyens. »*[18]

Comme le mentionnait un commentateur de la scène américaine, après avoir dit aux enfants que le cannabis est une drogue dangereuse, que se passera-t-il quand ils découvriront à l'école secondaire que leurs amis en consomment sans avoir les neurones grillés ? Adapter les messages aux clientèles, aux contextes et aux objectifs

---

[17] Dr Colin R. Mangham, directeur, Prevention Source B.C., témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 17 septembre 2001, fascicule 6, page 74.

[18] M. Michael J. Boyd, président du Comité sur la toxicomanie de l'Association canadienne des chefs de police et sous-chef du Service police de Toronto, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 11 mars 2002, fascicule 14, pages 77-78.

visés est sans doute nécessaire. Mais il est sûrement tout aussi nécessaire que les mesures de prévention disent la vérité aux enfants et aux adolescents, qu'elles parlent des effets connus des drogues et des carences dans nos connaissances. Si notre société tient des discours contradictoires sur le cannabis, ce n'est pas parce que certains activistes du pot manipulent les médias ; ou alors il nous faut douter de la capacité de nos médias à garder une neutralité et une distance critique. À la lumière des données épidémiologiques sur la consommation et celles de la recherche scientifique sur les effets du cannabis présentées aux chapitres 6 et 7, nous pensons que **le fait de tenir des discours alarmistes sur le cannabis est probablement contre-productif pour ceux mêmes qui souhaitent, et légitimement, en prévenir les abus.**

C'est là d'ailleurs l'un des éléments que souligne le récent rapport de Santé Canada sur les meilleures pratiques de prévention :

> *« Le principe le plus important pour n'importe quel programme, peu importe son but, est que l'information sur la drogue soit scientifiquement exacte, objective, sans parti pris et présentée sans jugement de valeur. (...) Même si les très jeunes participants acceptent les messages qui font ressortir uniquement les aspects négatifs de la consommation, il y a danger que es messages perdent toute crédibilité lorsqu'ils reçoivent de l'information plus précise. (...) Les messages qui veulent faire peur et qui s'accompagnent de données inexactes ou exagérées n'ont aucun effet ; ils peuvent au contraire susciter le scepticisme, l'irrespect, la résistance ou d'autres réactions à risque. (...) Parallèlement, les messages simplistes que les jeunes perçoivent comme étant irréalistes (il suffit de dire « non ») ou inapplicables (faites du sport alors qu'il n'y a aucune installation dans l'environnement immédiat) n'auront aucune crédibilité. »*[19]

Il existe une connaissance dont il faut s'inspirer

Il ne fait aucun doute qu'il existe une pratique de prévention répandue à travers le Canada, forgée le plus souvent à coup d'essais et d'erreurs, souvent portée à bout de bras et avec peu de ressources par des personnes qui y croient vraiment. Comme le démontrera la section suivante, il existe aussi un bassin de connaissances sur les actions les plus susceptibles d'agir efficacement sur les facteurs de risque et sur les processus les plus à même de soutenir des actions fortes de prévention.

L'une des difficultés provient du fait que cette « connaissance » reste trop fréquemment dans la tête de quelques personnes, notamment parce qu'il ne se fait pas d'études d'évaluation ou trop peu. Lorsqu'il y a des études, elles circulent dans des revues scientifiques et sont lues par des spécialistes mais ne rejoignent pas les praticiens. Et il existe encore peu de moyens systématiques de dissémination de l'information. Par ailleurs, se pose la question de l'adaptation à d'autres contextes des pratiques éprouvées ailleurs.

---

[19] Roberts, G. et coll., (2001) *op. cit.*, page 43.

> [Traduction] *« Nous suggérons au Comité qu'il serait plus utile de concentrer ses efforts sur la prévention que sur la réforme de nos bis sur les drogues. La Stratégie canadienne sur les drogues démontre que la prévention est la stratégie la plus efficiente. Si nous admettons que c'est vrai, ne devrions-nous pas faire porter notre attention sur les approches les plus susceptibles d'un bon retour sur investissement ? Dans un Compendium des meilleures pratiques publié par le Centre canadien de lutte contre l'alcoolisme et les toxicomanies, les auteurs attirent l'attention sur l'importance de l'influence parentale sur les comportements à risque chez les jeunes. (…) De nombreuses études menées par le Center on Addictions and Substance Abuse à l'Université Columbia sur les programmes de prévention arrivent à la même conclusion. »*[20]

> *« Enfin, nos années d'intervention et de prévention nous ont fait comprendre que le véritable problème n'est pas un problème de drogues, mais un problème personnel. En effet, toutes les personnes – en particulier les jeunes qui ont souffert de mauvais traitement, de négligence, de traumatisme et de la toxicomanie dans leur foyer – cherchent à trouver un soulagement à leur sentiment de colère, de désespoir et d'impuissance. Certains peuvent éprouver des sentiments d'ennui, de curiosité, ou un désir d'appartenance. La marijuana et les autres drogues peuvent donner l'impression d'éliminer ou tout au moins d'apaiser ces émotions. (…) En revanche, la prévention offre un énorme potentiel pour encourager les jeunes informés, confiants et compétents qui apprennent dès le plus jeune âge à faire appel à un raisonnement sain, pour répondre à ces sentiments humains, pressants et compréhensibles sans être incités à avoir recours à la drogue. »*[21]

PRÉVENIR : QUOI ? COMMENT ?

S'entendre sur la nécessité de la prévention, c'est un peu comme s'accorder sur l'importance de la vertu. Mais quelle prévention ? Le glossaire de l'Office des Nations Unies pour le contrôle des drogues et la prévention de la criminalité définit la prévention comme suit :

> [Traduction] *« Les actions de prévention incluent de vastes campagnes destinées à la population générale telles les activités d'information et d'éducation du public, des initiatives spécifiques à des collectivités et des programmes scolaires à l'intention des étudiants et plus largement des jeunes. Les actions de prévention peuvent aussi cibler les groupes vulnérables ou à risque, incluant les enfants des rues, les jeunes décrocheurs, les enfants de parents toxicomanes, les contrevenants en liberté surveillée ou en prison, etc..*
> *La prévention porte essentiellement sur les éléments suivants :*

---

20 Mémoire de *Focus on the Family Association* présenté au Comité du Sénat sur les drogues illicites, 14 mai 2002.

21 M. Art Steinman, Directeur général, *Alcohol-Drug Education Service*, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 7 novembre 2002, fascicule 10, page 90.

Sensibiliser, informer et éduquer au sujet des drogues et des effets négatifs de l'usage et de l'abus sur la santé et la société, et promouvoir des normes antidrogues et des comportements pro-sociaux contre l'usage de drogues ;
Aider les personnes et les groupes à acquérir les habiletés personnelles et sociales pour développer des attitudes antidrogues et éviter qu'ils s'initient aux comportements d'usage ;
Promouvoir un environnement aidant et des comportements et modes de vie alternatifs axés sur la santé, plus productifs et plus épanouissants, libres de drogues. »[22]

Il s'agirait donc d'agir de telle sorte à modifier les déterminants entraînant l'abus de drogues, où tout usage est abus lorsqu'il s'agit d'une substance illicite ou contrôlée par les conventions internationales. La définition identifie comme déterminant de l'abus l'initiation à l'usage des drogues, étant entendu que l'initiation mène, au moins chez des personnes dites «à risque » à un usage plus fréquent, voire à l'usage d'autres substances. Les domaines d'action proposés identifient indirectement d'autres déterminants : l'absence d'information sur les conséquences négatives de l'usage de drogues et des normes sociales insuffisamment antidrogues, des habiletés sociales et personnelles insuffisantes pour résister à l'usage de drogues, et des modes de vie insatisfaisants et qui ne sont pas axés sur la santé, seraient autant de déterminants de l'abus de drogues.

Mais en fait, que sait-on des raisons pour lesquelles on consomme des drogues, spécifiquement ici du cannabis ? On sait que les hommes consomment plus d'alcool et de drogues et les femmes plus de médicaments. Sait-on vraiment pourquoi ? On pense qu'il y aurait plus de 150 millions de consommateurs de cannabis sur la planète, et nous avons dit qu'il y en avait environ 3 millions au Canada annuellement ; faut-il conclure que ces personnes n'avaient pas les habiletés sociales et personnelles nécessaires pour résister aux drogues ? Quand, à quel moment, la consommation d'une drogue peut-elle être un choix ? Quand, à quel moment, la consommation devient-elle un problème ? Selon les réponses que l'on donne à ces questions, c'est toute la stratégie de prévention qui s'en trouve modifiée.

Au delà du bagage génétique, les déterminants de la santé des populations sont, entre autres, fonction :

« (...) des déterminants environnementaux qui sont liés au milieu dans lequel évolue l'individu, de sa conception à sa mort : environnement physique, mais aussi social. Éducation, emploi, revenu, tissu familial et social, répartition de la richesse, tous ces facteurs jouent un rôle. On reconnaît qu'un lien étroit existe entre le statut socioéconomique et l'état de santé et de bien-être : ce lien se vérifie à l'observation des données d'hospitalisation, d'incapacité, de problèmes de santé et de mortalité d'une population. Parmi les autres déterminants, il y a bien sûr les habitudes de vie et les comportements, comme le tabagisme et l'alimentation. Même s'il s'agit de facteurs modifiables, et souvent ciblés par la prévention, on sait aussi qu'ils sont largement conditionnés par les facteurs socioéconomiques. Enfin,

[22] UNDCP (2000) *op. cit.*, page 58.

dernier déterminant, les services de santé, dont le niveau et l'organisation varient selon la communauté, selon le pays. »[23]

Il est vrai que les données épidémiologiques tendent à indiquer que les jeunes consommateurs de cannabis proviennent davantage de milieux socioéconomiques désavantagés, qu'ils fument du tabac plus souvent, qu'ils ont probablement eu des parents fumeurs voire usagers de cannabis. C'est ce qu'on appelle des facteurs de risque reliés à l'environnement. Selon certains auteurs, les consommateurs habituels ou intensifs, ceux qui sont à risque, auraient aussi une plus faible estime de soi, une probabilité plus élevée de décrochage scolaire ou de ne pas terminer leurs études secondaires, un rendement scolaire moins élevé. Ce sont des facteurs de risque reliés à la personne.

En plus des facteurs de risque, le langage de prévention parle aussi de facteurs de protection. Le glossaire de l'Office des Nations Unies définit ce terme comme suit :

[Traduction] *« Facteur qui diminue la probabilité qu'un événement perçu comme indésirable se produise. Le terme est souvent employé en référence à des caractéristiques des personnes ou de l'environnement qui réduisent la probabilité de l'expérimentation de l'usage de drogues illicites. Par exemple, des études menées dans les pays développés indiquent que les facteurs suivants seraient, statistiquement du moins, des facteurs de protection contre l'usage de drogues : être de sexe féminin, être de niveau socioéconomique élevé, avoir un emploi, avoir un haut degré de scolarité, être pratiquant, et être non-fumeur. »*[24]

Les données épidémiologiques démontrent en effet que les femmes, les personnes qui ne fument pas de tabac, et les pratiquants consomment moins. Par contre, les données ne sont pas aussi claires quant à l'effet du statut socio-économique ni du niveau d'éducation.

L'un des textes clés de la littérature sur la prévention est certainement celui de Hawkins et coll., en 1995.[25] Les auteurs y présentent une liste exhaustive des facteurs de risque qui sont reliés, directement ou indirectement à l'abus de drogues, regroupés sous cinq catégories : individuels, familiaux, scolaires, relations avec les pairs, et contextuels. L'identification de ces facteurs provient d'un ensemble d'études longitudinales qui ont suivi des enfants et des adolescents sur de longues périodes de temps.

[Traduction] *« Des études longitudinales récentes ont identifié des facteurs de risque et des facteurs de protection qui prédisent de manière cohérente l'usage de drogues. De plus, les données indiquent que la*

---

[23] Direction de la Santé publique (1997) *Les inégalités sociales de la santé. Rapport annuel 1998 sur la santé de la population.* Montréal : Régie régionale de la santé et des services sociaux de Montréal-Centre.

[24] UNDCP, *op. cit.*, page 60.

[25] Hawkins, D.J., Arthur, M.W. & R.F. Catalano (1995) « Preventing Substance Abuse. » dans Tonry, M. et D.P. Farrington (eds.) *Building a Safer Society : Strategic Approaches to Crime Prevention,* Chicago : University of Chicago Press.

probabilité d'abus de drogues est plus élevée chez ceux qui sont exposés à des multiples facteurs de risque et que l'usage augmente de façon exponentielle avec la multiplication des facteurs de risque. Les niveaux élevés d'abus de drogues chez les personnes criminalisées et les sans abris sont cohérents avec les études sur les facteurs de risque personnels, sociaux et environnementaux qui prédisent l'abus de substances. Ces études suggèrent que des actions visant à prévenir l'abus de drogues doivent cibler des facteurs de risque multiples touchant la famille, l'école, les pairs et l'environnement. »[26]

1. *Des facteurs individuels* :
Parmi les facteurs individuels que la recherche a permis d'établir, les auteurs incluent : l'histoire familiale, le bagage génétique, les caractéristiques biochimiques, les problèmes précoces et persistants de comportement, l'aliénation et le caractère rebelle, les attitudes favorables à l'usage de drogues et l'initiation précoce.

2. *Des facteurs familiaux* :
Ces facteurs incluent : les comportements d'usage de substances ou la permissivité chez les parents, des pratiques parentales déficientes, des relations parents-enfants de mauvaise qualité, des conflits familiaux.

3. *Des facteurs scolaires* :
Ces facteurs incluent les échecs scolaires et un faible niveau d'engagement scolaire ; l'intelligence n'est pas un facteur, mais le milieu scolaire et les difficultés d'apprentissage sont des déterminants.

4. *Des facteurs liés aux relations avec les pairs* :
Le rejet par les pairs à l'école primaire et des pairs qui consomment des drogues sont aussi des facteurs reliés à l'abus de substances.

5. *Des facteurs environnementaux* :
La disponibilité des drogues, les normes juridiques et culturelles, la pauvreté et la désorganisation du milieu de vie.

Quant aux facteurs de protection, les auteurs identifient des caractéristiques individuelles (résilience, habiletés sociales et personnelles, intelligence), la qualité des relations à l'enfance dans la famille et à l'école notamment ; et des normes individuelles et sociales qui s'opposent à la consommation de drogues.

Ces facteurs ne doivent pas être confondus avec des causes. Il s'agit d'associations statistiques qui sont elles-mêmes limitées par divers problèmes méthodologiques relatifs entre autres à la mesure des comportements et à l'évaluation des effets des interventions.[27]

---

[26] Hawkins, D., *op. cit.*, page 368.
[27] Hawkins D., et coll., *op. cit.*, pages 363-367.

> *« Un des avantages certains de l'approche axée sur les facteurs de protection et les facteurs de risque est l'admission que de nombreux problèmes sociaux et problèmes de santé proviennent de la même source – une admission qui peut mener à une meilleure intégration des stratégies et à une économie des ressources. Toutefois, comme un facteur lié à des problèmes de consommation d'alcool et d'autres drogues n'en est pas nécessairement la cause, l'effet préventif de s'attaquer à l'un ou l'autre de ces facteurs n'est pas très clair et varie certainement selon les facteurs. Néanmoins, il semble bien que le fait de se pencher sur les facteurs de protection ou les facteurs de risque présents sous plusieurs aspects de la vie d'un jeune (vie personnelle, scolaire, familiale et communautaire) peut donner des résultats positifs. »*[28]

Hawkins et coll., examinent une série d'interventions – pré et néonatales, et préscolaires, au primaire et au secondaire – qui ont été évaluées. Selon eux, les stratégies les plus prometteuses sont les approches multidisciplinaires impliquant la collectivité.

> [Traduction] *« Les données suggèrent que des approches multistratégiques ciblant de multiples facteurs de risque sont prometteuses pour prévenir l'abus de substances. Le défi actuel de la recherche en prévention de l'abus de substances est de tester des stratégies de prévention qui habilitent les collectivités et leur permettent de concevoir et être en contrôle de leurs propres efforts de prévention pour identifier, prioriser et cibler les facteurs de risque et les facteurs de protection. »*[29]

La prévention n'est cependant pas un livre de recettes où l'on peut reproduire à l'identique une même formule. Les caractéristiques des collectivités locales, les solidarités sociales existantes, la force des organisations communautaires, sont autant de facteurs qui jouent un rôle clé dans le succès de l'intervention de prévention. De plus en plus, les auteurs s'entendent sur une série d'éléments de processus qui sont les mieux à même de façonner le succès. Le Compendium des pratiques publié par Santé Canada propose les éléments suivants :

- Bâtir un cadre solide
  - Facteurs de protection, facteurs de risque et ressort psychologique
  - Intégration
  - Durabilité et intensité
- Mettre l'accent sur la responsabilisation
  - Renseignements précis
  - Objectifs clairs et réalistes
  - Surveillance et évaluation
  - Durabilité envisagée dès le début
- Comprendre les jeunes et les faire participer
  - Évolution du développement psychosocial des adolescents
  - Perception des jeunes à l'égard de la consommation

---

[28] Roberts, G., et coll., (2001), *op. cit.*, page 26.
[29] Hawkins, D., et coll., *op. cit.*, page 404.

  - ➢ Participation des jeunes à l'élaboration et à l'exécution du programme
- Mettre en place un processus efficace
  - ➢ Messages crédibles
  - ➢ Développement simultané des connaissances et des compétences
  - ➢ Interaction entre les groupes
  - ➢ Excellence et formation des enseignants et des animateurs

Quelles sont les actions éprouvées et prometteuses ? Le Compendium propose une série de programmes d'interventions canadiennes mais dont aucune n'a véritablement été l'objet d'une évaluation rigoureuse.

Lors de nos audiences, plusieurs intervenants, notamment policiers, nous ont mentionné le programme DARE, pour *Drug abuse resistance education.*

> *« Nous utilisons une version canadienne adaptée du programme DARE qui ne correspond pas à ce que la plupart des citoyens entendent dire à son sujet depuis des années. Grâce à ce programme, nous obtenons de bons résultats et une meilleure acceptation. »* [30]

> *« Nous avons été dans l'impossibilité de continuer de financer les programmes canadiens mais il faut reconnaître que la GRC et toutes ses divisions ont su choisir un bon programme de remplacement avec DARE, le programme Drug Abuse Resistance Education américain. Il s'agissait d'un programme clé en main. Notre budget ne nous permet toujours pas de développer des programmes canadiens ni de procéder à des évaluations. Malheureusement – et c'est vraiment embarrassant – l'argent qui a dû être consacré à la formation des agents de police canadiens au programme DARE, soit un total de 250 000 $ a été fourni par les États-Unis. Le gouvernement canadien n'a financé aucune formation au programme DARE. »* [31]

Ce programme a été initié aux États-Unis au début des années 1980 par la police de la ville de Los Angeles. En 1996, ce programme était utilisé par 70 % des districts scolaires et rejoignait 25 millions d'étudiants. Environ 25 000 policiers américains ont été formés pour fournir les leçons du programme dans les écoles. Le programme est aussi utilisé dans 44 autres pays à travers le monde. Le programme comprend divers modules mis en œuvre diversement selon les collectivités. À la base, il inclut un programme de visites de la maternelle jusqu'à la quatrième année du primaire ou les enfants reçoivent de brèves leçons sur la sécurité personnelle, le respect des lois, et les drogues. Le programme principal de 17 semaines est destiné aux élèves de 5e et 6e année. Un programme de 10 semaines, destiné aux élèves du premier cycle du secondaire, porte sur la résistance aux pressions des pairs, la capacité à faire des choix

---

[30] M. Barry King, chef du Service de police de Brockville, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 11 mars 2002, fascicule 14, page 83.

[31] Surintendant principal R.G » Lesser, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 29 octobre 2002, fascicule 8, page 14.

personnels, la résolution de conflits et la gestion de la colère. Un autre programme de 10 semaines à l'intention des élèves du second cycle du secondaire porte sur les choix personnels et la gestion de la colère. Enfin, le programme DARE + est un programme après école, pour les jeunes du milieu du secondaire, orienté sur les activités récréatives. Le programme principal de 17 semaines pour les élèves de la fin du primaire est le plus fréquemment utilisé (81 % des districts scolaires américains). Il est offert par un policier en uniforme et porte sur les habiletés à résister aux drogues. Il donne des informations sur les drogues et leurs effets, l'estime de soi, des alternatives aux drogues. Le programme inclut des leçons magistrales, des discussions de groupe, des documents audio visuels, des exercices et des jeux de rôle.

Un document que nous a remis la GRC indique que le programme DARE est enseigné dans 1 811 écoles à travers le pays, dans 584 communautés différentes, à l'exception du Québec. L'Alberta vient en tête avec 150 districts scolaires, 583 écoles et plus de 21 400 étudiants rejoints en 2001. Elle est suivie de l'Ontario (40 districts, 346 écoles, 10 940 étudiants) et de la Colombie-Britannique (60 districts, 289 écoles, 10 800 étudiants). Toutes ces écoles offrent le programme principal de 17 semaines. En 2001, ce programme a rejoint plus de 53 000 étudiants. Au total, les diverses composantes de DARE ont rejoint plus de 65 000 élèves canadiens en 2001.

Nous ne savons pas dans quelle mesure le programme a été « canadianisé ». À notre connaissance, aucune étude d'évaluation d'impacts n'a été menée. Le document qui nous a été remis est la première phase d'une étude d'évaluation qui devrait, en deuxième phase, fournir des données sur les impacts. La première phase de l'étude porte sur les opinions, préférences et perceptions des élèves, professeurs et parents.[32] L'étude porte sur l'ensemble des étudiants de 5e et 7e année du primaire du district scolaire de Vancouver Ouest qui ont reçu le programme soit 500 et 570 respectivement, leurs parents et leurs enseignants. L'étude révèle un très haut niveau de satisfaction face au programme. Ainsi :

---

[32] Curtis, C.K. (1999) *The efficacy of the Drug Abuse Resistance Education program (DARE) in West Vancouver schools. Part 1 – Attitudes toward DARE : An examination of opinions, preferences, and perceptions of students, teachers, and parents.* GRC West Vancouver.

- 97 % des élèves, 95 % des professeurs, et entre 78 % et 94 % des parents selon le niveau étaient d'accord avec le programme et les objectifs du programme ;
- 78 % des professeurs étaient d'accord avec le contenu de DARE pour le niveau de leurs élèves ;
- 72 % des élèves considéraient que l'information reçue était valide et à jour ;
- 97 % des enseignants étaient très satisfaits du rapport entre le policer enseignant et les élèves ;
- 96 % des élèves disaient avoir compris les enseignements ;
- 88 % des élèves disaient que DARE les avait préparés à résister aux drogues au primaire et 58 % à y résister au secondaire ;
- Entre 82 % et 89 % indiquaient avoir une meilleure connaissance des dangers des drogues.

Ce ne sont là que quelques-uns des résultats. Ces données rejoignent d'ailleurs celles que l'on peut trouver sur le site Internet de DARE aux États-Unis et de plusieurs évaluations. Mais ce sont là des évaluations qui mesurent les opinions, perceptions et attitudes, non les comportements. On peut dire, dans une certaine mesure, que ces résultats, pour positifs qu'ils soient, sont en quelque sorte attendus.

Par contre, les évaluations qui ont cherché à mesurer les impacts du programme DARE sur les comportements, c'est-à-dire en particulier sur la prévention ou la réduction de l'usage ont à peu près systématiquement démontré que le programme n'avait aucun impact ou que des impacts très faibles et de courte durée.

Le Compendium des bonnes pratiques préparé pour Santé Canada contient une section spéciale sur le programme DARE. Il y est écrit :

> *« LE D.A.R.E. a fait l'objet d'évaluations et d'examens nombreux, mais de peu d'évaluations scientifiques rigoureuses. Bien que certaines évaluations fassent état de résultats positifs, des études parues dans des publications approuvées par les pairs, y compris une étude prospective sur cinq ans et une méta-analyse des évaluations des résultats de D.A.R.E. ont constamment révélé que le programme ne permet pas de prévenir ou de retarder la consommation de drogues, ni d'influer sur les intentions d'en consommer. En revanche, le programme semble stimuler les attitudes antidrogues, du moins à court terme, accroître les connaissances sur les drogues et favoriser des relations positives entre la police et les membres de la communauté. En outre, le taux d'acceptation du programme est généralement élevé chez les policiers qui le présentent, les élèves et leurs parents. »*[33]

On peut bien entendu attribuer l'absence d'impacts du programme aux exigences de l'évaluation. Ce sont cependant les mêmes qui sont utilisées pour d'autres programmes.

[33] Roberts, G. et coll., *op. cit.*, page 192.

En 1997, un rapport important a été déposé au Congrès américain, à sa demande, par une équipe de chercheurs prestigieux de diverses universités américaines pour faire le point sur ce qui marche, ne marche pas et est prometteur en prévention de la criminalité.[34] Voici ce qu'a dit ce rapport du programme DARE :

> [Traduction] *« Plusieurs évaluations du programme original principal de 17 leçons ont été menées. L'Institut national de la Justice a fait un résumé dans une méta-analyse des effets à court terme de D.A.R.E. Cette synthèse a identifié 18 évaluations du programme principal de D.A.R.E., huit d'entre elles atteignant les critères méthodologiques suffisants pour faire partie de la méta-analyse. Les auteurs ont trouvé que :*
>
> *1. Les effets à court terme sur l'usage de drogues, à l'exception du tabac, ne sont pas significatifs ;*
> *2. Les effets sur l'usage de drogues sont faibles, ne dépassant pas 0,6 en moyenne pour l'usage de drogues et ne dépassant jamais 0,11. Les effets sur les facteurs de risque associés à l'abus de substances sont aussi petits : 0,11 pour les attitudes et 0,19 pour les habiletés sociales ;*
> *3. D'autres programmes ciblant le même groupe d'âge que D.A.R.E. sont plus efficaces (…).*
>
> *Quatre autres rapports récents, dont trois études longitudinales, n'ont pas réussi à trouver d'effets positifs à D.A.R.E. Lindstrom (1996), dans une étude relativement rigoureuse sur un échantillon d'environ 1 800 étudiants en Suède, n'a pas observé de différences significatives sur les mesures de délinquance, d'usage de substances ou d'attitudes favorables à l'usage, entre les étudiants qui ont reçu et ceux qui n'ont pas reçu le programme D.A.R.E.. Sigler et Talley (1995) n'ont pas observé de différences dans les comportements d'usage des élèves de 7 année à Los Alamos au Nouveau-Mexique, entre ceux qui avaient et n'avaient pas reçu le programme D.A.R.E. 11 mois plus tôt. Rosenbaum et coll., (1994) rapportent une étude portant sur 12 paires d'écoles (échantillon total de près de 1 600 élèves) qui étaient assignées aléatoirement en écoles recevant et écoles ne recevant pas le programme. Bien qu'ayant observé quelques effets positifs immédiatement après le programme, les auteurs n'ont observé aucune différence significative sur l'usage de tabac ou d'alcool entre les élèves des deux groupes d'écoles au début de l'année scolaire suivante. (…) Ces études, et des rapports récents dans les médias, ont critiqué D.A.R.E. parce que le programme (a) ne met pas suffisamment l'accent sur le développement des habiletés sociales et trop sur les connaissances et les attitudes ; (b) repose sur des cours et des discussions plutôt que sur des méthodes interactives ; (c) recourt à des policiers en uniforme qui ne sont pas formés pour enseigner et ont donc de moins bonnes relations avec les élèves.*
>
> *(…)*
>
> *En somme, sur la base des critères méthodologiques utilisés dans notre étude, D.A.R.E. ne marche pas pour réduire l'usage de substances. (…) Aucune donnée scientifique n'indique que le programme principal de D.A.R.E. tel que conçu à l'origine et révisé en 1993 diminuera l'usage de substances en l'absence d'une formation plus axée sur le développement des compétences sociales. »*[35]

Ces informations sont du domaine public. Elles sont disponibles depuis plusieurs années. Considérant le peu de ressources qui sont consacrées à la prévention de l'abus de drogues au Canada, les autorités fédérales et la GRC auraient eu intérêt à en prendre connaissance avant de décider d'implanter même une version canadianisée du

---

[34] Sherman, L.W. et coll., (1997) *Preventing Crime : What Works, What Doesn't, What's Promising.* A Report to the United States Congress. Washington, DC : US Department of Justice.
[35] *Ibid.*, pages 5-33 à 5-35.

programme DARE. Au delà de la rhétorique qui peut plaire, il y a dans ce cas-ci, et c'est si rare qu'il faut savoir en profiter, des études rigoureuses qui démontrent que ce programme n'atteint pas les objectifs qu'il dit viser.

La même étude identifie d'ailleurs d'autres programmes beaucoup plus susceptibles d'avoir des résultats positifs sur l'usage et l'abus de drogues, notamment les programmes de formation aux habiletés sociales. Le Compendium canadien décrit aussi un certain nombre de programmes qui ont été évalués de manière rigoureuse et ont montré des résultats positifs.

Comme l'un de nos témoins, nous nous interrogeons donc fortement sur cette pratique développée dans le monde policier de faire l'éducation aux drogues dans les écoles :

> *« J'aimerais commenter brièvement les programmes d'éducation antidrogues présentés par la police. Personnellement, nous avons quelques réserves au sujet des programmes d'éducation présentés pendant de longues heures par des agents de police. Nous ne pensons pas qu'il soit financièrement viable de demander à des agents de police de présenter des programmes d'éducation antidrogues pendant des heures et des heures à tous les niveaux d'une école. Les enseignants ont reçu une formation d'éducateur. On leur a appris comment augmenter l'estime de soi et comment donner aux élèves une plus grande confiance en leurs compétences. Nous savons que la plupart des agents de police sont sérieux et bien intentionnés, mais nous craignons que certains d'entre eux n'aient pas, à notre avis, la formation suffisante pour donner le type d'éducation requise. J'ai également certaines réticences vis-à-vis d'une toute nouvelle initiative mise en œuvre par le programme DARE aux États-Unis. (…) ils devraient se poser la question qui est la personne la mieux qualifiée pour présenter ce programme ? Des élèves et des professeurs nous ont dit qu'une éducation antidrogues présentée par un agent de police est parfois plus autoritaire et qu'elle contribue moins à aider les jeunes à faire eux-mêmes des choix mûrement réfléchis, mais tend plutôt à leur imposer un choix précis. »* [36]

Nous pensons que **l'éducation aux substances psychoactives, aux comportements d'usage et aux risques qui y sont associés, est nécessaire. Mais nous pensons qu'il faut repenser les approches et que les policiers, s'ils doivent y être associés, ne doivent pas en être les maîtres d'œuvre ni non plus ceux qui assurent la formation des élèves.**

Indépendamment de la liste des facteurs de risque et de protection que l'on dresse et de la liste de programmes gagnants que l'on fait, il importe d'avoir une vision holistique de la prévention puisque le phénomène des drogues s'inscrit lui-même dans un environnement social, culturel, historique et complexe. L'examen des discours et des pratiques de prévention démontre que l'un des risques consiste à proposer une conception réductionniste et mécaniste de la santé des personnes et des collectivités. Nous avons constaté au chapitre 6 que, les données disponibles indiquent une augmentation de la consommation de cannabis chez les jeunes de niveau secondaire.

---

[36] M. Art Steinman, Directeur général, *Alcohol-Drug Education Service*, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 7 novembre 2002, fascicule 10, page 86.

Nous avons aussi vu au chapitre 10 que l'opinion publique serait plus tolérante qu'auparavant. Et nous avons vu dans le présent chapitre que peu d'efforts ont été consentis au titre de la prévention. Faut-il pour autant, affirmer, comme l'a fait le Centre canadien de lutte contre l'alcoolisme et les toxicomanies, que l'augmentation de la consommation résulte de la simple addition de ces facteurs ?

> *« La résurgence du phénomène général de la drogue tel que nous le connaissons aujourd'hui est largement le fait de la jeunesse en général, ce qui représente peut-être le plus lourd tribut que nous devons payer pour avoir modifié notre cible et négligé cette population au cours de la deuxième phase (de la stratégie nationale, ndlr.). À toute fin pratique, il est que notre effort de prévention doit viser tous les jeunes sans exception. Le Centre croit que tous les jeunes – premier de classe comme décrocheurs – sont vulnérables à la consommation de la drogue et devraient être considérés comme faisant partie intégrante des populations à risque. »*[37]

Est-ce vraiment l'effet des efforts de prévention mené au cours de la première phase de la stratégie (1987-1992) qui peut expliquer la relative diminution des niveaux de consommation au cours de cette période ? Est-ce vraiment l'absence de discours et pratiques de prévention au cours des années 1990 qui peuvent rendre compte de l'augmentation de l'usage ? À strictement parler, on n'en sait rien. Non seulement n'y a-t-il pas eu une évaluation de la phase I de la stratégie nationale, mais même l'évaluation la plus rigoureuse n'aurait pu l'établir de manière certaine. On pourrait tout aussi bien relier l'augmentation des niveaux de consommation des années 1990 à une série de facteurs tout autres tels la réduction des services gouvernementaux, la contraction du marché de l'emploi pour les jeunes, voire la globalisation des marchés mondiaux qui induit un sentiment d'impuissance devant les conditions de vie. Ou d'autres facteurs encore qui nous échappent pour le moment.

Aux États-Unis, la consommation de substances illicites a diminué au cours de la période 1982-1991, pour recommencer à augmenter à compter de 1993. Les politiques et les approches ont-elles changé ? Les taux d'incarcération pour délits reliés aux drogues n'ont certainement pas diminué. Autant d'argent sinon davantage a été investi dans les programmes de prévention et d'éducation. Le taux d'usage d'alcool chez les jeunes de moins de 17 ans avait aussi diminué ; peut-on l'attribuer aux mêmes mesures ? Inversement, le taux d'usage du tabac n'avait à peu près pas changé malgré des campagnes d'éducation et de prévention au moins aussi fortes. Alors ? Si l'on peut certes attribuer une partie de la diminution de l'usage de drogues illicites aux politiques de « guerre à la drogue », il n'est pas certain que cette explication soit suffisante. Et il faudrait aussi se demander à quel coût social et économique.

> [Traduction] *« La "guerre à la drogue" du gouvernement américain a mené à une expansion incroyable des ressources destinées à la réduction de l'offre et à la lutte au trafic des drogues illicites ainsi qu'à*

---

[37] Centre canadien de lutte contre l'alcoolisme et les toxicomanies (1996) *La politique antidrogue au Canada. Mémoire au Comité permanent de la Santé de la Chambre des communes.* Ottawa : auteur.

imposer des sanctions de plus en plus sévères contre les usagers, incluant ceux qui sont trouvés en possession de quantités relativement petites de drogues illicites. Ces politiques ont apparemment eu peu d'effets sur la disponibilité des drogues addictives ou sur la réduction de l'abus. Elles ont fait exploser les coûts associés à la construction de prisons et à l'augmentation extraordinaire de la population carcérale, incitant plusieurs personnes à demander la légalisation des drogues prohibées telles la marijuana et la cocaïne. »[38]

À travers tout cela, on laisse peu de place pour une conception moins mécaniste des individus. C'est ce que nous rappelait le professeur Malherbe dans le texte qu'il a préparé à notre demande :

« La réalité vécue par des humains est toujours plus complexe et multifactorielle et aucun énoncé de risque se référant à un facteur unique n'a de signification pour un sujet individuel (même si des corrélations semblent bien établies). (…) Aucune prévision n'est possible de l'avenir d'un individu singulier sur base d'informations statistiques. On est donc en droit de se demander parfois quel est le niveau de formation scientifique (ou d'honnêteté) des médecins qui confondent corrélation statistique, facteur de risque et cause. Il est vrai cependant qu'il est plus commode de « faire la morale » aux gens que de les soutenir et de les éclairer dans le cheminement souvent chaotique de leur liberté vers une plus entière responsabilité à l'égard d'eux-mêmes, des autres et de la fragile biosphère à laquelle tous nous appartenons. »[39]

Et plus loin :

« La vraie nuisance, la pire de toutes, la plus intolérable, la seule qui doive absolument être réprimée est celle qui consiste à vouloir faire le bonheur des gens en creusant leur peur de la maladie et de la mort et sans leur demander à chacun d'exercer ses choix personnels et de réaliser ses préférences. La vraie, l'unique nuisance, est le fait de l'idéologie sanitaire, de la **furor sanandi** *qui dessine notre bonheur sans que nous puissions y prendre goût. Est-ce dire que tout soit permis indistinctement ? Certes non ! Mais le critère reste à découvrir pas à pas au fil de nos essais et de nos erreurs et ne saurait être imposé par des experts – médecins ou économistes – au nom d'un ordre a priori et mortifère. Mieux vaut pour la vie la joie d'un désordre fécond que l'ennui d'une planification dont l'arbitraire n'aurait d'égal que la stérilité. »*[40]

Il convient aussi que la prévention, surtout dans les écoles, soit un lieu de discussion et d'ouverture qui permette la responsabilisation des jeunes ainsi qu'une acculturation des substances. La démonisation et l'endoctrinement ne tiennent jamais lieu d'éducation.

---

[38] Hawkins, D.J., Arthur, M.W. & R.F. Catalano (1995) « Preventing Substance Abuse. » dans Tonry, M. et D.P. Farrington (eds.) *Building a Safer Society : Strategic Approaches to Crime Prevention, Chicago : University of Chicago Press,* page 344.

[39] Malherbe, J.F. (2002) *Contribution de l'éthique à la définition de principes directeurs pour une politique publique sur les drogues.* Document préparé pour le Comité spécial du Sénat sur les drogues illicites. Ottawa : Sénat du Canada, page 7.

[40] *Ibid.*, page 10.

RÉDUCTION DES RISQUES, RÉDUCTION DES MÉFAITS

L'approche de réduction des méfaits s'est imposée comme outil privilégié d'intervention pour la prévention de la contamination au VIH Sida par suite d'injection de drogues par voie intraveineuse. On s'est en effet aperçu, à la fin des années 80, que les usagers des drogues injectées étaient un vecteur important de transmission du VIH. Les programmes d'échange de seringues, par exemple, sont nés de cette approche.

Mais l'approche de réduction des méfaits pose une série de difficultés conceptuelles et théoriques. D'abord sur les termes eux-mêmes. En anglais, le terme le plus souvent utilisé est *harm reduction*, mais on voit aussi parfois le terme *risk reduction.* En français, on a traduit harm reduction par réduction des méfaits, mais aussi par réduction des dommages et réduction des risques.

De plus, le concept et la pratique de la réduction des méfaits font l'objet de critiques de la part d'un certain nombre d'observateurs qui y voient des stratégies de légalisation camouflée des drogues.

> *« Lorsque je parle de « politique de réduction des méfaits » je ne pense pas à la politique que nous avons mise en œuvre jusqu'ici. Nous avons tenté de nombreuses expériences comme celle de l'échange de seringues et nous avons mis à l'essai l'approche de réduction des méfaits pour ce qui est de la conduite en état d'ivresse. J'ai conçu de nombreux programmes destinés aux jeunes parce que c'est ma spécialité. Si on me demandait d'élaborer un programme en vue d'enseigner aux jeunes comment utiliser de façon modérée et sans risques les drogues qui sont illicites aujourd'hui, je ne pense pas que je saurais comment le faire. La consommation de drogues entraîne toujours des effets. L'héroïne peut être la plus pure au monde, mais la personne qui la consomme peut-elle fonctionner au sein de sa famille et dans la société et a-t-elle les moyens de payer pour la drogue qu'elle s'habituera à consommer ? Voilà les questions auxquelles il faut répondre. Lorsque j'utilise le terme « réduction des méfaits » je l'utilise dans son sens originel. Le terme a malheureusement pris une autre connotation. À l'origine, l'objectif visé était noble, mais le terme signifie maintenant décriminalisation ou légalisation des substances. Je vous mets en garde contre l'utilisation de ce terme tel qu'il est maintenant compris. »*[41]

Il est vrai que les stratégies de réduction des méfaits sont souvent sur une trajectoire de collision avec les stratégies d'application de la loi : la situation s'est souvent présentée dans plusieurs villes du pays où des héroïnomanes sortant d'une clinique d'échange de seringues se trouvaient nez à nez avec des policiers.

Le terme réduction des méfaits renvoie plus spécifiquement aux stratégies visant à réduire les conséquences négatives de la consommation de drogues sur la santé, la

---

[41] Dr. Colin Mangham, *op. cit.*, page 73.

situation économique et l'environnement social, pour l'usager et pour son entourage.[42] Au delà de l'échange de seringues, les stratégies de réduction des méfaits pour les usagers de drogues incluent des actions telles la prescription de méthadone pour les héroïnomanes, des programmes de prescription d'héroïne sous surveillance médicale, ou des cliniques d'injection sans prescription. Les intervenants canadiens s'entendent pour dire que ces diverses mesures sont sous-développées au Canada. Le ministère fédéral de la Santé a récemment annoncé qu'un programme de prescription d'héroïne serait testé dans trois grandes villes du pays. Le nombre de place de méthadone serait insuffisant. Quant aux cliniques d'injection – *safe injection rooms* – elles sont inexistantes.

Quelles sont les implications d'une stratégie de réduction des méfaits pour le cannabis ? Quelles en seraient les applications possibles ? Les stratégies de réduction des risques reliés par exemple à l'héroïne ont été basées sur la connaissance de certains des méfaits reliés à l'usage intraveineux de cette drogue : VIH et hépatite C pour les usagers (programmes d'échange de seringues), l'insalubrité des lieux d'injection et les risques de violence (cliniques d'injection), petite criminalité contre les biens pour payer les doses (prescription d'héroïne). Pour élaborer des stratégies de réduction des méfaits, il faut donc connaître au moins certains aspects des modes de consommation de la drogue et ses effets nocifs, directs ou indirects. Quels sont les méfaits reliés au cannabis ?

Aux chapitres 7 et 8, nous en avons identifié quelques-uns dont :

- Des risques pour les jeunes de moins de 16 ans en raison de l'immaturité de leur développement physiologique, notamment de leur système cannabinoïde endogène ;
- Des risques associés à une consommation qu'on pourrait qualifier d'occupationnelle (plutôt que récréative), caractérisée notamment par une consommation seul, le matin, pour réaliser des activités scolaires ou professionnelles ;
- Des risques associés à une consommation intensive et fréquente sur une longue durée ;
- Des risques associés à l'inhalation du produit sur une longue durée ;
- Des risques associés à la conduite sous l'influence, surtout lorsque combiné avec l'alcool.

C'est donc à partir de cette connaissance que des stratégies de réduction des risques pourraient être élaborées pour le cannabis. Ainsi :

- Décourager l'usage pour les moins de 16 ans ;
- Dépistage des consommateurs à risque, spécifiquement chez les jeunes ;

[42] Par exemple, voir les travaux de D. Riley (1996) *Harm Reduction : Concepts and Practice. A Policy Discussion Paper.* Centre canadien de lutte contre l'alcoolisme et les toxicomanies ; ainsi que le document de réflexion que Dr Riley avait préparé pour le Sénateur Nolin.

- Informer sur les risques de l'inhalation et que l'inhalation profonde fait partie du folklore et n'est pas nécessaire pour obtenir les effets ;
- Dissuader par des moyens forts la conduite sous l'influence.

Évidemment, comme pour les stratégies de réduction des méfaits pour les autres drogues, ces outils reposent sur la reconnaissance de l'usage et une approche qui ne postule pas l'abstinence. Nous sommes bien conscients que ces deux prémisses pourront susciter de vives réactions chez ceux qui croient que le cannabis est foncièrement dangereux et nous mettre en porte-à-faux par rapport au contexte juridique actuel.

CONCLUSIONS

La prévention est nécessaire. Rappelant nos principes directeurs, elle doit s'inscrire dans une vision du rôle de la gouvernance comme moyen de favoriser l'action humaine et dans une vision de l'éthique et de la santé publique qui doivent mettre l'accent sur l'autonomie. En ce sens, prévenir n'est pas contrôler mais participer à l'émancipation. Et dans le cas du cannabis qui nous concerne, émancipation ne signifie pas obligatoirement non-usage mais capacité de prise de position et de réflexion par rapport aux motifs et raisons de l'usage, et d'intervention autonome sur les conduites à risque.

Conclusions du chapitre 16	
Sur la prévention	**➢ La prévention n'est pas une stratégie de contrôle mais une manière d'habiliter les acteurs sociaux, individuels et collectifs, à prendre des décisions informées et à acquérir des outils pour éviter les conduites à risque.** **➢ Une stratégie nationale sur les drogues devrait investir significativement en prévention.** **➢ Les stratégies de prévention doivent être en mesure de tenir compte des connaissances sur les drogues.** **➢ Les messages de prévention doivent être crédibles, vérifiables, neutres.** **➢ Les stratégies de prévention doivent être globales, multifactorielles et impliquer la collectivité.** **➢ Les stratégies de prévention dans les écoles ne devraient pas être pilotées par les organisations policières ni offertes par des policiers.** **➢ La GRC devrait reconsidérer son choix du programme DARE.**
Sur l'évaluation	➢ Une stratégie de prévention doit prévoir l'évaluation

	rigoureuse d'un certain nombre de mesures clés. **➢ Une stratégie nationale sur les drogues devrait prévoir des mécanismes permettant la dissémination large des connaissances issues de la recherche et de l'évaluation.** **➢ Les évaluations doivent éviter le réductionnisme, doivent impliquer les acteurs de prévention, doivent s'intégrer au programme et doivent prévoir l'évaluation des impacts sur une base longitudinale.**
Sur la réduction des risques	**➢ Des stratégies de réduction des risques en matière de cannabis devraient être élaborées en concertation avec les acteurs du domaine de l'éducation et des services sociaux.** **➢ Des stratégies de réduction des risques en matière de cannabis devraient inclure une information sur les risques associés à l'usage du cannabis, des outils de dépistage des usagers à risque et des usagers excessifs, et des moyens de lutte contre la conduite sous l'influence du cannabis.**

CHAPITRE 17

PRATIQUES DE SOINS

À l'exception des traitements offerts aux Autochtones et aux contrevenants incarcérés dans les institutions fédérales, les soins aux personnes ayant des dépendances relèvent essentiellement des provinces et territoires. Ce chapitre sera donc bref puisque nous n'avons reçu que quelques mémoires et témoins traitant de cette question.

Afin de mettre cette discussion en contexte, nous rappelons d'abord quelques données relatives aux dépendances induites par le cannabis et ses dérivés. Nous examinons ensuite les diverses formes de traitements disponibles. Enfin, nous nous penchons brièvement sur les connaissances relatives à l'efficacité des traitements.

DÉPENDANCES AU CANNABIS

Clarifions d'abord la terminologie. Nous avons vu au chapitre 7 que, même si le terme toxicomanie revient le plus souvent pour désigner les personnes qui ont un problème de dépendance aux substances psychoactives, l'OMS avait recommandé de l'abandonner dès 1963 pour cause d'imprécision. Nous lui préférons le terme de dépendance, plus englobant, et qui peut s'appliquer à toutes sortes de conduites addictives qu'il s'agisse de substances (aliments, alcool, drogues illicites) ou d'activités (jeu, sexe, sports extrêmes). En matière de substances psychoactives, nous distinguons, avec l'OMS, entre dépendance psychique et dépendance physique :

> *« La dépendance psychique est un « état dans lequel une drogue produit un sentiment de satisfaction et une pulsion psychique exigeant l'administration périodique ou continue de la drogue pour provoquer le plaisir ou éviter le malaise.*
> *La dépendance physique est un « état adaptatif caractérisé par l'apparition de troubles physiques intenses lorsque l'administration de la drogue est suspendue ou que son action est contrecarrée par un antagoniste spécifique. Ces troubles, c'est-à-dire les symptômes de sevrage ou d'abstinence, se composent de symptômes et de signes de nature physique ou psychique qui sont caractéristiques de chaque drogue. »* [1]

---

[1] OMS (1964) *Comité d'experts des drogues engendrant la dépendance*, Série de rapports techniques, no 273, cité in Caballero et Bisiou, *op. cit.*, pages 5-6.

Alors que la dépendance est décrite comme un état physiologique ou psychologique induit par la consommation prolongée et abusive d'une substance, la toxicomanie a une connotation de maladie mentale, sinon une connotation morale. Certains d'ailleurs, le NIDA par exemple, n'hésitent pas à faire de la toxicomanie une véritable maladie qui aurait des composantes génétiques. Dans cette perspective, l'usage de drogues déclencherait des mécanismes biophysiologiques menant à l'addiction. D'où l'accent sur l'abstinence. Au Canada, les programmes de traitement ont tendance à considérer les dépendances comme un phénomène bio-psychosocial mais « on continue toutefois, dans certains secteurs de services, d'appuyer les différentes versions du traitement fondé sur la notion que l'alcoolisme et la toxicomanie sont des maladies ».[2] Il est d'ailleurs intéressant de noter que les programmes de réadaptation pour alcoolisme seraient plus nombreux (51 %) que les programmes pour « toxicomanie » (47 %) à admettre une stratégie de réduction des méfaits et donc des objectifs autres que ceux de l'abstinence.[3]

Ces précisions faites, le Comité a été frappé par l'ambivalence de la terminologie selon la langue utilisée. En anglais, le nom du Centre canadien de lutte contre l'alcoolisme et les toxicomanies est le *Canadian Centre on Substance Abuse* (centre canadien sur l'abus des substances). En français, la brochure du ministère du Solliciteur général décrivant les activités de son portefeuille ministériel s'intitule *La lutte contre la toxicomanie*, et en anglais *Countering Substance Abuse* (combattre l'abus de substances). Au Québec, l'organisme gouvernemental est le Comité permanent de lutte à la toxicomanie. En plus de porter une charge morale forte, le vocable toxicomanie appelle un vocabulaire de lutte, de combat, tandis que le terme abus de substances est plus neutre, plus posé pourrait-on dire. L'écart entre les deux langues ne s'explique pas pourtant par l'absence d'un substantif approprié : à *drug addiction* correspond en français un choix de termes : addiction (plus ou moins heureux) ou dépendance. Un peu de rigueur et de clarté ne nuirait sûrement pas tenant compte de l'émotivité du débat sur les drogues.

Ayant distingué entre les usages, les conduites à risque et les usages excessifs, nous pensons qu'il convient, logiquement, d'éviter le terme toxicomanie et de référer plutôt aux dépendances induites par l'usage excessif. Il conviendrait d'ailleurs que les organismes et ministères fédéraux modifient et accordent leur terminologie entre les deux langues.

Quelle fréquence de dépendances au cannabis ? Nous avons établi au chapitre 7 que la dépendance physique au cannabis est certainement rare et mineure. Certains symptômes d'accoutumance et de tolérance sont identifiables chez les usagers chroniques de longue date, mais la plupart d'entre eux n'ont aucun mal à arrêter et n'ont pour la plupart pas besoin de sevrage.

---

[2] Roberts, G. et A. Ogborne (1998) *Profil, Alcoolisme et toxicomanie. Traitement et réadaptation au Canada.* Ottawa : Stratégie canadienne antidrogue, ministère de la Santé, page 18.

[3] *Ibid.*

Quant aux formes de dépendance psychologique, les études sont encore incomplètes, mais les données internationales tendent à indiquer qu'entre 5 % à 10 % des usagers réguliers (au moins au cours du dernier mois) sont à risque de développer une dépendance au cannabis. Rappelant que chez les adultes environ 3 % ou 600 000 Canadiens auraient consommé du cannabis au cours du dernier mois et qu'environ 100 000 ou 0,5 % en feraient un usage quotidien, nous avons estimé qu'entre 30 000 et 40 000 en feraient un usage à risque et qu'entre 5 000 à 10 000 en feraient un usage excessif. Chez les jeunes de 16 et 17 ans, entre 50 000 et 70 000 seraient à risque et entre 8 000 et 17 000 feraient un sauge excessif. Nous avions aussi vu que la période de consommation la plus intensive se produirait entre 17 et 25 ans. C'est dire que c'est à l'intérieur de ces paramètres qu'il faut chercher à prévenir la dépendance au cannabis et offrir les services de réadaptation nécessaires.

Quelle forme prend la dépendance au cannabis ? La plupart des auteurs s'entendent pour dire que la dépendance psychologique au cannabis est relativement mineure. En fait, elle n'aurait rien de comparable avec la dépendance au tabac ou à l'alcool, et serait même moins importante que la dépendance à certains médicaments psychotropes. La cessation de consommation durant deux à quatre semaines, qui s'accompagne de certains symptômes semblables à ceux de la cessation de la nicotine (insomnie, irritabilité, transpiration, etc.), suffirait généralement à faire disparaître les symptômes. Lorsque des formes de traitement s'imposent, pour un certain nombre de personnes, elles sont moins longues et moins difficiles que celles pour dépendance à l'alcool ou aux drogues « dures ». Il est aussi notable que les demandeurs de traitement pour dépendance au cannabis soient plus jeunes que ceux qui suivent un traitement pour dépendance aux autres drogues. Divers facteurs peuvent expliquer cet état de fait : la consommation de cannabis est davantage un phénomène de jeunesse que les autres substances, elle atteint son pic au début de la vingtaine et diminue significativement après la fin de la vingtaine ; remarquons aussi que les jeunes qui ont besoin d'un traitement manifestent aussi des problématiques de polytoxicomanie, le cannabis n'étant pas la seule drogue consommée.

La sortie de la dépendance ou d'une consommation que l'usager en vient à considérer comme abusive, se fait souvent par choix personnel et ne requiert pas nécessairement une intervention thérapeutique.

> *« Il y a ce qu'on appelle la rémission spontanée. Vers la trentaine, beaucoup de comportements d'abus de substance ou de consommation cessent ou sont plus modérés. Il y a un phénomène de maturation évident en ce qui concerne la consommation de drogues.*
> *Chez les consommateurs de longue date, il y a aussi le phénomène de la mise à la retraite, c'est-à-dire de la lassitude face au style de vie lié à la consommation de drogues : il y a une perte d'intérêt pour la quête incessante du produit et pour ce que cela apporte comme gratification. En fait, c'est carrément un type*

d'analyse coût-bénéfices où l'individu en vieillissant se dit que le jeu n'en vaut plus la chandelle. Il considère que les conséquences négatives de sa consommation ne valent plus le coup. »[4]

« La majorité des personnes qui éprouvent des problèmes d'alcool et de drogues ne reçoivent aucune aide, mais les faits démontrent clairement que celles qui bénéficient de certaines formes de traitement réduisent leur consommation de substances psychotropes et montrent aussi, par la suite, une amélioration personnelle à maints égards. En règle générale, les résultats du traitement seront d'autant meilleurs que l'on s'occupera simultanément de traiter les principaux problèmes de l'existence (communication, manque de confiance en soi, chômage). »[5]

Il y a de bonnes raisons de penser que, pour ce qui est du cannabis, la majorité des usagers à problème n'ont pas recours aux diverses formes de traitement, et qu'ils n'en ont vraisemblablement pas besoin. D'abord parce que les effets du cannabis ne sont pas aussi prononcés que ceux d'autres drogues. Ensuite parce que les usagers de cannabis sont plus souvent des personnes socialement intégrées que les usagers de drogues dures, leur permettant de compter sur leurs réseaux naturels d'entraide. Troisième raison selon nous qui expliquerait que la majorité des usagers de cannabis peuvent se sortir d'une trajectoire de dépendance : l'usage n'est pas associé à la « toxicomanie », à la déchéance, dans les représentations sociales et dans l'imaginaire collectif, comme peut l'être l'usage d'héroïne par exemple. De plus, une étude canadienne a indiqué que « seulement 3 % des consommateurs de drogues illicites ont déclaré avoir demandé une aide quelconque pour leurs problèmes de toxicomanie. »[6]

Au demeurant, comme pour toute substance psychoactive, un certain nombre de personnes choisissent ou ont besoin d'un traitement.

« On a d'ailleurs observé dans les groupes en traitement – et c'est une hypothèse – qu'il y a deux groupes de personnes qui cherchent à mettre un terme à leur consommation. Premièrement, il y a les gens qui ont surtout consommé des opiacés de façon régulière depuis six ans et plus. Deuxièmement, il y a le groupe des consommateurs qui consomment depuis deux ans et moins et qui ne veulent plus composer avec les effets secondaires des drogues. »[7]

La décision de traitement serait notamment déterminée par l'accroissement des difficultés sociales et personnelles que poserait la consommation de la substance, et par une comorbidité avec des troubles d'ordre psychiatrique.[8] Les femmes font systématiquement moins demande de services de traitements spécialisés pour drogues et alcoolisme ; on peut expliquer cette situation par le fait que l'offre de service est

---

[4] Dr Céline Mercier, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 10 décembre 2001, fascicule 12, page 9.
[5] Robert, G. et A, Ogborne (1999) *Meilleures pratiques – Alcoolisme et toxicomanie. Traitement et réadaptation.* Ottawa : Stratégie canadienne antidrogue, page 5.
[6] Roberts et Ogborne (1999) *op. cit.*, page 64.
[7] Dr Céline Mercier, *ibid.*
[8] Roberts et Ogborne, *op. cit.*, page 65.

moins grande et que les femmes sont prises en charge autrement par des services psychiatriques traditionnels.

Mais les personnes ne choisissent pas toujours, ou du moins pas totalement. Les pressions familiales ou du milieu de travail, et dans certains cas les exigences judiciaires, sont autant de facteurs qui mènent au traitement. De surcroît, on connaît peu de choses des trajectoires des personnes qui consomment des drogues de manière excessive, a fortiori de celles qui demandent un traitement. Par exemple, on ne sait pas dans quelle mesure le fait d'aboutir en traitement serait davantage le fait d'autres problématiques antérieures – problèmes familiaux, problèmes psychiatriques – que de la consommation de la substance elle-même. Pour les usagers de drogues qui ont par ailleurs des démêlés avec la justice et une trajectoire délinquante, les comportements déviants et délinquants précèdent souvent l'entrée sur une trajectoire de dépendance aux drogues, comme l'a démontré le chapitre 6. La demande de traitement dans ces cas sera au moins autant motivée par le fait de devoir, ou de vouloir, mettre fin à une carrière criminelle qu'aux effets de l'usage de substances.

Peut-on, doit-on forcer au traitement ? C'est l'une des questions soulevées par l'apparition en France de l'obligation de soins dans la Loi sur les stupéfiants de 1970, devenue depuis l'injonction thérapeutique,[9] et des tribunaux spéciaux sur les drogues (*drug courts*) aux États-Unis d'abord et maintenant au Canada.

Au Canada, certains articles du *Code criminel* portent sur l'obligation pour certains contrevenants de suivre des traitements lorsqu'ils sont des problèmes reliés à l'alcool ou aux drogues. Ainsi, dans le cadre d'une ordonnance de probation, la cour peut ordonner :

- Que le contrevenant, s'il y consent, et sujet à l'approbation du responsable de l'organisme visé, suive un traitement approuvé par la province ; et
- Que le contrevenant se présente à un organisme pour évaluation et traitement curatif pour consommation d'alcool ou de drogues (lorsque la province a établi un tel programme).[10]

De plus, lorsque le tribunal impose une sentence conditionnelle, l'une des options lui permet d'ordonner que le contrevenant suive un traitement auprès d'un organisme approuvé par la province.[11]

Sauf exception, un tribunal n'ordonnera pas un traitement pour des problèmes reliés à l'alcool ou aux drogues si la personne n'a pas été trouvée coupable d'une infraction criminelle. L'une de ces exceptions concerne la détention des personnes ayant des problèmes de santé mentale en vertu de la législation provinciale sur la santé

---

[9] Nous décrivons plus en détail le système français au chapitre 20.

[10] *Code Criminel*, paragraphes 732.1(3)(g) et (g.1).

[11] *Code Criminel*, paragraphe 742.3(2)(e).

mentale. Ces lois prévoient dans quelles conditions une personne peut être détenue aux fins de traitement contre son gré.

La décision de la Cour suprême du Canada dans *Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.)*[12] illustre bien la réticence des tribunaux à imposer un traitement pour abus de substances. Dans cette affaire, une jeune femme autochtone enceinte de cinq mois et déjà mère de trois enfants avait une dépendance à la colle dont la consommation peut endommager le système nerveux du fœtus. Les services à l'enfance et à la famille de Winnipeg ont demandé au tribunal la permission de détenir la jeune femme contre son gré pour lui imposer un traitement. Examinant les faits en cause à partir de la question des droits du fœtus, la Cour a décidé que ni la « *tort law* » ni la juridiction *parens patriae* des tribunaux ne justifiaient une ordonnance de détention et de traitement d'une personne aux fins de prévenir des préjudices au fœtus.

En France, l'injonction thérapeutique, sous-utilisée, a fait l'objet de sévères critiques notamment à cause de l'imposition du traitement. La question demeure ouverte malgré des évaluations mitigées des résultats de cette pratique.[13]

> *« L'injonction thérapeutique fonctionne aussi en France depuis 1970. Une étude avec une collègue de l'Institut national de santé et de recherche médicale en France a démontré que beaucoup de gens étaient perdus en cours de route parce qu'il y avait une injonction thérapeutique qui les obligeait à suivre un traitement. Ces gens ne recevaient jamais de traitement, faute de place, faute de suivi. Si on veut instaurer les « drug courts » au Canada, il faudra prévoir et bien préparer ces mécanismes de concertation avec les systèmes de traitement pour être bien sûr que les services de traitement sont disponibles. Sinon, c'est un peu un leurre de créer des drug courts si les personnes se perdent dans les failles du système. »*[14]

On estime qu'environ 10 % des détenus incarcérés dans les institutions fédérales le sont pour infractions à la Loi sur les drogues. Par ailleurs, et c'est encore plus important, on estime qu'au moins 50 % de tous les détenus, que ce soit dans les prisons provinciales ou dans les centres fédéraux de détention, ont des problèmes de dépendances (alcool et drogues).[15] Or, au total, peu de détenus reçoivent une quelconque forme de traitement.[16] Aux États-Unis, des études indiquent que moins de 10 % des détenus reçoivent des traitements pour dépendances pendant leur incarcération.[17]

---

[12] [1997] 3 S.C.R. 925.

[13] Simmat-Durand, L. (1999) «Les obligations de soins en France. » in Faugeron, C., (dir.) *Les drogues en France. Politiques, marchés, usage.* Paris : Georg.

[14] Dr Serge Brochu, professeur à l'école de criminologie de l'Université de Montréal, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 10 décembre 2001, fascicule 12, page 25.

[15] Brochu, S. (1995) *Drogues et criminalité. Une relation complexe.* Montréal : Presses de l'Université de Montréal.

[16] Voir là-dessus le chapitre 15.

[17] Lipton, D.S. (1995) *The effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision.* Washington, DC : National Institute of Justice.

Dans le cas des institutions provinciales, cette situation s'explique par la courte durée des sentences et par les coupures budgétaires dans les institutions correctionnelles au début des années 1990. Dans le cas des institutions fédérales, les programmes de traitement sont offerts mais ils sont loin de suffire aux besoins. De surcroît, il peut être dans une certaine mesure ironique d'offrir des programmes de traitement dans des institutions où les drogues circulent et où il n'est pas rare que les détenus aient accès notamment au cannabis.

Néanmoins, les traitements offerts aux détenus demeurent une composante essentielle d'une réinsertion réussie quand on connaît l'ampleur des problèmes de dépendance aux drogues, surtout les plus dures, et à l'alcool.

Une dernière remarque. Certains intervenants ont fait part d'une observation à l'effet que le maintien au cannabis pourrait, dans certains cas, être un adjuvant à d'autres formes de sevrage et de traitement pour dépendances aux opiacés.[18] Il n'y a – et pour cause ! – aucune étude sur la question à notre connaissance. Rappelons toutefois, comme nous l'avons vu au chapitre 5, que les systèmes cannabinoïdes et les opioïdes sont en interaction complexe et qu'il est permis de penser que la consommation de Δ9-THC pourrait induire une réponse dopaminergique susceptible de diminuer le sevrage aux opiacés.

FORMES DE TRAITEMENT

L'étude de Single en 1992 sur les coûts de la consommation abusive d'alcool et de drogues avait estimé à environ 290 millions $ les dépenses relatives au traitement spécialisé de ces dépendances. Il convient toutefois de préciser que la majeure partie de ces dépenses concerne le traitement de la dépendance à l'alcool : pour le traitement résidentiel, 181 millions $ étaient dépenses pour l'alcool contre 21 millions $ pour les drogues illicites, et pour le traitement ambulatoire, 82 millions $ pour l'alcool et 8 millions $ pour les drogues.[19]

La majorité de ces sommes proviennent des provinces et des territoires. Le gouvernement fédéral finance directement la réadaptation des membres des Premières Nations vivant en réserve, des membres de la GRC et des Forces armées, des détenus en institution fédérale, et des personnes n'ayant pas vécu assez longtemps dans une province pour être admissibles au régime provincial d'assurance-santé.

Ceci dit, les ressources limitées consacrées au traitement des dépendances, de même que des pressions à la hausse en raison du nombre et de la diversité des bénéficiaires, limitent la disponibilité des services.

---

[18] Ceci nous a été mentionné lors d'une rencontre avec le personnel du Club de compassion de Vancouver.

[19] Single, E., et coll., *op. cit.*, page 42.

« De nombreux organismes ont subi d'importantes compressions au cours des dernières années. Qui plus est, les organismes de lutte à l'alcoolisme et aux toxicomanies sont de plus en plus pressés de s'occuper, par surcroît, des problèmes de jeu compulsif. (...) En outre, la loi C-41, qui stipule qu'un juge peut, à sa discrétion, ordonner à quelqu'un de suivre un traitement, a un effet sur les ressources des services d'évaluation et de traitement. »[20]

Il n'est probablement pas exagéré de dire que le champ des traitements pour toxicomanie est un champ complètement éclaté. Éclaté entre la pratique individuelle de thérapeutes, les groupes de soutien et d'entraide tels les narcomanes anonymes, ou les communautés thérapeutiques ; entre les approches pharmacologiques, cognitivistes et behaviorales, psychanalytiques, humanistes, systémiques ; entre les tenants du libre choix de l'usager et ceux qui favorisent le traitement imposé, c'est toute la variété des approches et des formes qui a cours.

Divers documents récents produits pour Santé Canada en témoignent. Le profil des programmes de traitement indique qu'il existait, en 1998, au moins 1 200 programmes différents et environ 7200 conseillers professionnels à travers le pays.[21] Ils se répartissent en traitement ambulatoire, traitement de jour ou de soir, traitement en milieu résidentiel de courte ou de longue durée, services d'approche et services de crise. La répartition de ces diverses approches selon les provinces et les territoires permet de voir quelles sont les formes privilégiées.

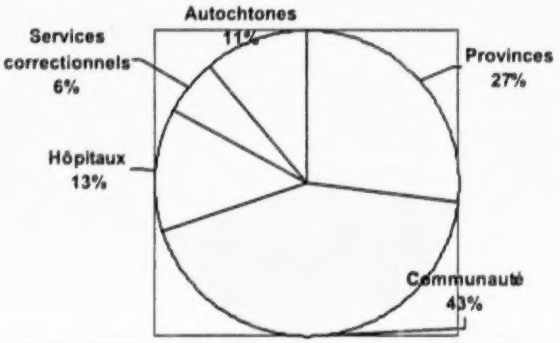
Services de traitement offerts au Canada[22]

	Ambulatoire	Jour / Soir	Résidentiel court terme	Résidentiel long terme	Approche	Crise	Total
TN&L	13	2	5	0	2	7	29
NE	9	7	7	6	9	4	42
I.P.É.	2	1	1	1	1	2	8
NB	5	3	3	2	3	5	21
Qc	72	52	59	43	48	44	318
Ont	110	55	43	51	61	64	384
Man	12	5	8	10	8	10	53
Sask	24	9	10	5	14	14	76
Alta	41	22	22	13	14	27	139
BC	128	43	39	28	70	77	385
TNO	7	5	3	2	7	7	31
Yukon	2	1	2	0	0	2	7
TOTAL	425	205	202	161	237	263	1493

[20] Roberts, G. et A. Ogborne, *op. cit.*, page 25.
[21] Roberts, G. et A. Ogborne, *op. cit.*, page 6.
[22] *Ibid.*, page 8.

L'affiliation première des programmes permet aussi de déceler leur orientation. Pas moins de 43 % des programmes de traitement sont des organismes communautaires. D'où la précarité de leur financement. Au total, les programme se répartissent comme suit :[23]

Affiliation première des programmes de traitement



Les trois formes principales de réadaptation sont les centres de désintoxication, les établissements de courte durée et les établissements de longue durée. Les personnes ayant une dépendance à l'alcool forment entre 60 et 70 % de la clientèle.

Quant aux approches thérapeutiques, 31 % recourent à la confrontation et 40 % à la psychothérapie, mais il existe une grande disparité entre les provinces et territoires ainsi qu'à l'intérieur d'une même province.[24]

L'EFFICACITÉ DES TRAITEMENTS

Insistons à nouveau sur le fait que nous ne sommes pas en mesure de discuter spécifiquement des traitements pour dépendances au cannabis. À notre connaissance, aucune étude d'évaluation portant sur l'efficacité de ces traitements n'a été menée. De plus, sur l'ensemble des programmes de traitement et de réadaptation existant au Canada, environ 14 % auraient fait l'objet d'études d'évaluation indépendantes.[25]

---

[23] *Ibid,* page 14.

[24] *Ibid.*, page 20.

[25] Roberts, G. et A. Ogborne, *op. cit.*, page 15.

Malgré l'absence de données systématiques, il semble permis de dire que les orientations des traitements des dépendances aux drogues sont principalement cognitivistes et comportementalistes. Cognitivistes, ils travaillent surtout à la prise de conscience de l'existence d'un problème de dépendance : informations objectives et mécanismes d'introspection visent à faciliter cette connaissance. Comportementalistes, les traitements visent à faciliter le changement des habitudes de vie. On sait en effet que la consommation de drogues s'inscrit dans un mode de vie, autour d'un groupe de relations, avec fréquentation de lieux spécifiques. La modification des modes de vie contribue à faciliter l'abstinence.

Quelle en est l'efficacité ? La plupart des auteurs qui ont examiné les programmes de traitements aux dépendances s'entendent pour dire qu'au delà des dimensions humanistes du traitement, il existe un bassin de connaissances permettant de conclure qu'ils sont relativement efficaces.

Plus précisément, la plupart des études, notamment des études menées au Québec, démontrent que les personnes qui demandent de l'aide dans les centres de réadaptation s'améliorent.

> *« (...) les personnes qui entreprennent une démarche de réadaptation dans les services offerts au Québec améliorent leur situation. (...) cette amélioration se maintient pendant la période de six mois à un an qui suit le traitement. Il s'agit d'un résultat positif et rassurant. Il va dans le même sens qu'un très grand nombre d'autres études menées principalement au cours des vingt dernières années. »*[26]

Sur un plan technique, les études ne permettent pas de conclure qu'une approche est plus efficace qu'une autre. Le rapport préparé pour la Stratégie canadienne antidrogue fait état de deux méga synthèses des études d'évaluation de 24 modalités de traitement réalisées aux États-Unis et démontre que les deux groupes de chercheurs, s'ils s'entendent pour reconnaître l'efficacité d'un certain nombre de formes de traitement... ne s'entendent cependant pas parfaitement sur l'ordre. Nous reproduisons la partie du tableau qui concerne les approches les plus efficaces.[27]

---

[26] Monsieur Michel Landry, *L'impact des traitements offerts au Québec aux personnes toxicomanes*. Mémoire présenté au Comité spécial du Sénat sur les drogues illicites, novembre 2001.

[27] Roberts et Ogborne (1999) *op. cit.*, page 9. Notons que ces traitements s'appliquent à toutes les dépendances, et que la majorité des études d'évaluation portent sur l'alcoolisme.

Classification des modalités de traitement efficaces selon deux groupes d'auteurs

Indice Holder	Modalité	Modalité	Indice Finney et Monahan
18	Apprentissage social	Appui communautaire	59
17	Cours en maîtrise de soi	Apprentissage social	37
13	Counselling en motivation de courte durée	Psychothérapie conjugale, comportementale	36
12	Psychothérapie conjugale, comportementale	Disulfirame, implants	34
6	Appui communautaire	Psychothérapie conjugale, non comportementale	21
6	Cours en gestion du stress	Cours en gestion du stress	12
3	Disulfirame, oral	Thérapie par aversion chimique	3
3	Thérapie par aversion, sensibilisation cachée	Médicaments psychotropes, antidépresseurs	2

Les études ne nous permettent même pas de conclure que ce soit le traitement en soi qui fasse la différence et, pour certains auteurs, la décision de s'inscrire dans une démarche de traitement, quelle que soit la forme du traitement, serait plus déterminante. Les études ne permettent pas non plus de préciser la durée idéale du traitement, mais il semble qu'au-delà de 9 à 12 mois, les effets plafonneraient. Par ailleurs, il est difficile de déterminer l'impact de l'intensité du traitement (combien d'heures par jour, de jours par semaine).

Enfin et surtout, les impacts positifs portent principalement sur les habitudes de consommation et sur l'état psychologique général. Les traitements auraient cependant peu d'effets sur la réinsertion sociale des personnes, dimension particulièrement importante lorsqu'il s'agit de détenus.

Finalement, le traitement est plus efficace et certainement moins dispendieux que l'incarcération. Au Canada, on estime que le traitement ordonné par un tribunal sur les drogues coûte environ 4 500 $ par personne tandis que l'incarcération coûte en moyenne 45 000 $. Même avec un taux de succès de 15 %, il ne fait pas de doute qu'il s'agit d'une mesure à la fois économique pour la société et plus en phase avec les besoins réels des contrevenants qui ont des problèmes de dépendance. Plus généralement, on admet que le rapport coût-bénéfices du traitement a été bien démontré :

> *« La preuve des avantages économiques du traitement des problèmes de drogues autres que l'alcool provient d'une vaste étude sur le traitement des drogués réalisée aux États-Unis par le collectif Hubbard en 1989. Cette étude réunissait les données provenant de plus de 10 000 usagers de drogues et visait 37 programmes de traitement axés sur trois grandes modalités de traitement : le traitement à la méthadone, le counselling ambulatoire de toxicomanes devenus abstinents et la communauté thérapeutique. (...) Deux mesures de synthèse des coûts avaient été établies, soit d'une part, les coûts pour les citoyens respectant la loi et, d'autre part, les coûts pour la société. Les premiers incluaient les coûts de crimes reliés aux dommages ou pertes matériels, des pertes de productivité dues aux blessures ou*

à des inconvénients reliés à la drogue et des procédures de la justice pénale. Les coûts pour la société comprenaient les coûts pour les victimes d'activités criminelles reliées à la drogue, les coûts des procédures de la justice pénale et les coûts engagés au titre d'activités criminelles, à cause des pertes touchant le développement professionnel et la productivité pendant que les usagers de drogues ne gagnent pas un revenu légitime. Les résultats ont révélé que, parmi la population étudiée, les deux catégories de coûts étaient inférieures après le traitement et que les écarts entre les périodes d'avant et d'après traitement excédaient les coûts du traitement. »[28]

CONCLUSIONS

Conclusions du chapitre 17

- **Il convient d'abandonner le terme de toxicomanie et de parler d'abus de substances et de dépendances.**
- **Entre 5 % à 10 % des usagers réguliers de cannabis seraient à risque de développer une dépendance.**
- **La dépendance physique au cannabis est à peu près inexistante.**
- **La dépendance psychologique est modérée et certainement moindre que pour la nicotine ou l'alcool.**
- **La plupart des usagers réguliers de cannabis se sortiraient d'une trajectoire de dépendance sans avoir besoin de traitement.**
- **Il existe de multiples formes de traitement mais on ne connaît rien de l'efficacité spécifique des traitements pour les dépendances au cannabis.**
- **Règle générale, le traitement est plus efficace et moins dispendieux qu'une sentence d'incarcération.**
- **Il y aurait lieu de mener des études sur les programmes de traitement et notamment sur les traitements des personnes ayant des dépendances au cannabis.**
- **Il y aurait lieu de mener des études sur l'interaction du système cannabinoïde et du système opioïde.**

---

[28] Roberts et Ogborne, (1999) *op. cit.*, page 74.

CHAPITRE 18

OBSERVATIONS SUR LES PRATIQUES

Nous avons jusqu'à présent décrit l'action publique en la découpant selon les grands secteurs d'intervention. Avant de clore cette troisième partie du rapport, nous voulons poser quelques observations d'ensemble qui coupent à travers l'ensemble des champs spécifiques que nous avons examinés. La première de ces observations concerne les difficultés d'une articulation entre les paliers et secteurs d'intervention, la seconde sur la difficulté d'arrimer les approches entre elles, et la troisième sur les coûts des drogues et des politiques publiques.

DES DIFFICULTÉS D'ARTICULATION ENTRE LES ACTEURS

Sans reprendre les débats sur les partages des pouvoirs et des responsabilités entre les divers paliers de gouvernement, il est clair qu'une politique publique sur les drogues illicites, sur le cannabis en particulier, concerne chacun des trois paliers. Les drogues touchent à l'éducation et à la santé (principalement du ressort provincial), à la justice (partagé entre le fédéral et les provinces), à la sécurité des milieux de vie (chacun des trois paliers de gouvernement y joue un rôle), aux relations internationales (relevant du fédéral), voire à la culture et à la science et la recherche (essentiellement du domaine provincial). Pourtant, force est de constater que, sur ce terrain, nous avançons dans le meilleur désordre.

Il existe des mécanismes de coordination. Au niveau le plus formel, le Groupe de travail fédéral-provincial-territorial des sous-ministres de la Santé a pour fonction de coordonner la stratégie antidrogues. Mais nous connaissons peu de choses de ces discussions privées et de leurs résultats concrets.

Le Centre canadien de lutte contre l'alcoolisme et les toxicomanies en est un. Mais il n'a de partenaires équivalents que dans quelques provinces (l'Ontario, le Manitoba, l'Alberta, le Québec bien qu'avec des réserves). Et le Centre n'a pas les budgets, l'infrastructure, voire la légitimité que lui conférerait un rôle clair et fort, pour faire se produire un véritable dialogue national sur la question.

Le partenariat santé – éducation et services de police en est un autre. Créé en 1994 et coordonné par le Centre canadien de lutte contre l'alcoolisme et les

toxicomanies, le réseau de Santé et services de police en partenariat (SSPP) s'inscrit dans une démarche structurée autour de la recherche d'un équilibre entre la réduction de l'offre et de la demande à l'instar de l'approche préconisée par la Stratégie canadienne antidrogue. Le SSPP réunit des intervenants clés des secteurs de la santé et des services de police dans la recherche d'un objectif commun, et englobe d'autres partenaires qui en font partie intégrante tels notamment les secteurs de l'éducation, des services sociaux, des services correctionnels et de la justice. À l'échelle nationale, le Comité directeur du SSPP se compose de représentants de la Fondation manitobaine de lutte contre les dépendances, de l'Association canadienne des chefs de police (coprésidence), du Centre canadien de lutte contre l'alcoolisme et les toxicomanies (coprésidence), du Service correctionnel du Canada, de la Fédération canadienne des municipalités, de Santé Canada, du ministère de la Justice du Canada, du Centre national de prévention du crime, de la Gendarmerie royale du Canada et du ministère du Solliciteur général. Combien de lecteurs connaissaient l'existence de ce partenariat, même parmi ceux qui sont actifs en matière de drogues ? Combien connaissent quelles en sont les réalisations, les actions concrètes, les bénéfices ?

Nous avons décrit, au chapitre 14, une réponse policière d'application inégale à travers le pays, entre régions, entre provinces et territoires, à l'intérieur même des provinces et territoires, entre villes. Nous avons vu, au chapitre 15, une réponse judiciaire dont tout donne à penser qu'elle est tout aussi différenciée, tout aussi morcelée. Les chapitres 16 et 17 sur les pratiques préventives et de soin respectivement ont démontré le même fractionnement, la même inégalité entre les approches.

Le Canada est une fédération et il est normal que des orientations et des pratiques différentes coexistent. La manière de penser et de vivre les questions du cannabis ne sont pas les mêmes dans la grande région de Vancouver qui a connu une explosion des plantations, qu'au Québec avec ses gangs de motards criminalisés, ou qu'à l'Île-du Prince-Édouard qui ne connaît à peu près pas de problèmes de production, voire même d'abus de cannabis. Les difficultés des zones centres des grandes villes ne sont pas les mêmes que celles des zones urbaines. Et les populations autochtones vivent, elles aussi, des problématiques spécifiques.

Néanmoins, les difficultés d'articulation entre les niveaux de gouvernement signifient entre autres, concrètement, au quotidien :

- Qu'une expérience de prévention forte menée dans un coin du pays ne parvient pas aux acteurs d'une autre partie.
- Que des pratiques thérapeutiques que des évaluations concluantes auraient révélé être inefficaces sont implantées ailleurs faute de la circulation de cette information.
- Qu'il n'y a pas une infrastructure nationale de connaissance sur les usages et les tendances d'usage : par exemple, les quelques études en milieu scolaire qui sont menées ne sont pas comparables et n'ont pas la même temporalité.
- Que des villes adoptent des politiques axées sur une société sans drogue tandis que d'autres optent pour une approche de réduction des méfaits.

Par surcroît, que dire de ce grand absent qu'est la société civile, notamment du milieu associatif (les organismes de réadaptation par exemple), mais aussi des groupes d'autosupport des usagers (pensons aux organismes de compassion pour usagers de cannabis aux fins thérapeutiques) dans l'élaboration des politiques publiques.

Sans tomber dans l'hystérie collective qui voudrait que les drogues soient un fléau, ce qu'elles ne sont pas, il n'empêche que la consommation de substances psychoactives, illicites comme licites, et les problèmes de dépendances qui en découlent, concernent tous les citoyens, tous les paliers de gouvernement, partout au pays. Il s'agit donc véritablement d'une *question nationale.* Et si nous admettrons aisément que la santé de notre système de santé, la protection de nos intérêts et de notre sécurité nationale, la qualité de l'éducation, ou la protection de l'environnement, sont autrement plus importants que les drogues, il n'empêche qu'il s'agit tout de même d'une *priorité nationale.* Ce devrait, du moins être le cas. Au delà des conséquences sociales et économiques dont il sera question un peu plus loin, il s'agit d'une priorité parce que la question des drogues touche à l'éducation des enfants et des adolescents, parce qu'elle affecte la qualité et la sécurité dans les milieux de vie, parce qu'elle occasionne des souffrances et des vies perdues. Ce n'est pas tant le cas du cannabis certes, dont les impacts sociaux et économiques n'ont rien de comparable à ceux de l'alcool. Mais nous ne perdons pas de vue que la question du cannabis, tout en appelant un traitement différencié, ne peut être considérée isolément des autres substances psychoactives. Il s'agit bien de créer une véritable politique nationale sur les drogues et les dépendances, au sein de laquelle le cannabis trouvera sa place.

Une meilleure articulation entre les paliers et avec la société civile permettrait de créer les bases d'une vision partagée des enjeux posés par les substances psychoactives, et surtout d'élaborer en commun des indicateurs permettant de mesurer à terme l'efficacité des politiques et des actions.

UN ARRIMAGE DIFFICILE ENTRE LES APPROCHES

Tenant compte des données de recherche que nous avons recueillies sur le cannabis, force est de constater qu'un certain nombre de mythes ont la vie dure. Le cannabis drogue d'escalade, le cannabis dangereux pour les fonctions cérébrales à long terme, le cannabis cause d'échec scolaire, et tant d'autres, ne sont tout simplement pas supportés par les résultats de la recherche.

Nous sommes bien conscients qu'il n'existe pas un consensus entre les chercheurs du monde entier sur ces questions. Et nous sommes conscients aussi de la difficulté de modifier les préconceptions. Lors d'une conférence scientifique internationale qui s'est tenue en Europe en 2002 et dont nous avons rapporté les travaux, il s'est trouvé des intervenants pour conclure que, malgré les consensus qui se dégageaient parmi la communauté des chercheurs, cette connaissance ne comptait pas puisque de toute

façon les pays représentés étaient tous signataires des conventions internationales. Comme quoi on trouve toujours à s'esquiver lorsqu'on refuse la réalité !

Mais au delà, ce n'est peut-être pas tant les acteurs terrain qu'il faudrait pointer du doigt. Les policiers, les intervenants dans les milieux thérapeutiques, sont confrontés, jour après jour, aux conséquences négatives de l'usage de drogues : criminalité et violence pour les uns, déchéance humaine pour les autres. Leur vision des drogues, du cannabis en particulier, est nécessairement colorée par cette expérience de terrain qui les met en contact avec les situations d'abus, la détresse, la violence, les accidents mortels. Mais les usagers qui font une demande de traitement ne sont pas plus représentatifs de la population des usagers de cannabis que ne le sont les jeunes de rue et petits délinquants que les policiers voient au quotidien.

Clairement, il manque un pont, un traducteur, entre les mondes de la production de la connaissance et de la pratique du terrain. Il manque un pont aussi entre les décideurs politiques et les acteurs, et entre eux et la société civile. Même si la recherche est imparfaite, même si nous avons déploré entre autres l'absence d'un véritable système de connaissance national, l'information est là, en quantité, comme nous avons été à même de le constater au cours de nos travaux. Mais elle doit circuler largement. Et surtout, elle doit faire l'objet de débats et de discussions publics. C'est un rôle que le CCLAT devrait jouer si on lui en donnait les moyens. C'est un rôle qu'il n'a jamais eu les moyens d'accomplir.

Les chercheurs portent aussi une part de responsabilité. Ils ne se préoccupent pas toujours ni de la lisibilité de leurs travaux par les décideurs, ni même de leur distribution dans les centres de décision politique et les milieux de la pratique. Ils sont parfois encore pris dans le carcan de leur « liberté académique », considérant que le fait de se mêler aux mondes de la décision et de la pratique risquent de contaminer l'objectivité de leurs travaux. Il n'est pas étonnant alors que les acteurs sur le terrain soient prisonniers de la seule connaissance dont ils disposent, celle que leur pratique leur fournit, et que leurs institutions d'attache ne sont pas nécessairement outillées pour systématiser et mettre en contexte.

Nous avons constaté un clivage important entre les positions des chercheurs et celles de plusieurs praticiens, notamment ceux des milieux policiers et du traitement. Il serait trop facile de réduire aux intérêts corporatistes les prises de position des praticiens. Il y a un travail préliminaire de discussion et d'échanges qui ne se produit pas entre les divers groupes d'acteurs et où trop souvent la « connaissance » issue de la pratique ne trouve pas de légitimité aux yeux des chercheurs, alors même qu'elle attire l'attention des décideurs, des médias et du public généralement.

Sur le terrain, cette difficulté se traduit par des contradictions flagrantes entre les discours et les approches des uns et des autres. Alors que les jeunes entendent parler des bénéfices thérapeutiques potentiels du cannabis et de sa «décriminalisation » ils voient en même temps des opérations policières dans les écoles et assistent à des conférences sur les dangers du cannabis. Alors que les trafiquants sont censés être la cible principale de la répression, ils lisent que des milliers de personnes sont arrêtées

pour possession de cannabis chaque année. Alors que les images de *junkies* happés par l'héroïne circulent dans les médias, ils entendent aussi parler de prescription médicale d'héroïne. Et il arrive encore que des usagers de drogues par injection soient cueillis par des policiers à leur sortie d'une clinique d'échange de seringues. Entre ces discours et pratiques contradictoires, comment s'y retrouver ?

L'arrimage des pratiques est rendu encore plus difficile par le déséquilibre des pouvoirs et des moyens. Les organismes de compassion fournissant du cannabis thérapeutique en ont parlé longuement : la relation qu'ils entretiennent avec les organismes d'application de la loi repose souvent sur une crédibilité bâtie au fil des ans avec quelques policiers, mais ils connaissent pertinemment la précarité de leur statut et qu'ils peuvent « sauter » à tout moment. Les agents de santé publique qui tiennent un discours et implantent une pratique de réduction des risques savent tout aussi bien qu'ils sont à la limite de la légalité et que leurs actions ne font pas l'unanimité. Les chercheurs qui voudraient mener des études sur les applications thérapeutiques du cannabis sont contraints par le système actuel de prohibition.

En matière d'alcool nous avons un système décisionnel susceptible de placer les acteurs des divers secteurs sur un relatif pied d'égalité : entre les régies qui contrôlent les processus de production, distribution et vente, les organismes de santé publique qui travaillent à réduire les comportements à risque et à connaître les déterminants de l'abus, et le système de justice qui intervient pour lutter contre la contrebande et arrêter les personnes irresponsables qui conduisent sous l'influence d'une drogue, il y a une concertation étroite et un dialogue constants. Il y a même des lieux de concertation et de dialogue avec l'industrie. On constate dans l'ensemble une uniformité des pratiques et des discours, ce qui ne signifie pas pour autant que tous les problèmes soient aplanis. Rien de cela en matière de drogues illicites. Des tables de concertation où certains mots ne peuvent être dits, où certaines décisions ne peuvent jamais être prises, où les ressources sont réparties très inégalement entre les acteurs, ne peuvent être que des « arbres à palabres » pour se donner l'illusion qu'il y a une réelle concertation.

DES COÛTS ÉCONOMIQUES ET SOCIAUX IMPORTANTS[1]

Le Centre canadien de lutte conte l'alcoolisme et les toxicomanies a publié en 1996, une première étude sur les coûts reliés à l'abus d'alcool, de tabac et de drogues au Canada.[2] L'estimation des coûts soulève des questions techniques difficiles : Quels aspects faut-il inclure ? Comment mesurer chaque élément ? L'analyse des coûts d'une politique publique sur les drogues repose sur l'hypothèse qu'un certain nombre des coûts sociaux reliés à l'usage des drogues pourraient être réduits voire éliminés. Ces coûts sont au moins de deux ordres : les coûts relatifs aux politiques publiques, principalement les coûts de la prévention et de la répression, ainsi que ceux de l'administration de la politique publique ; et les coûts évitables si les problèmes relatifs à l'abus de substances étaient éliminés, ce qu'on appelle le scénario « contre-factuel ». Les conséquences des drogues sont alors traitées comme coûts sociaux, c'est-à-dire comme réduction du bien-être collectif. Ce qui revient à dire que les consommations de drogues n'entraînent que des coûts sociaux, des externalités en langage économique.

Pourtant, d'une part, les consommations de drogues, qu'on soit moralement en accord ou non importe peu ici, peuvent aussi générer des bénéfices – même s'ils sont à court terme et dans une certaine mesure «irrationnels» – pour les personnes qui les consomment, voire même pour leur entourage. Les personnes hyperactives que l'usage de cannabis calme, celles dont la productivité est améliorée par l'usage de cannabis, celles dont les souffrances psychiques ou physiques sont atténuées et qui peuvent mieux fonctionner, ou tout simplement les usagers qui relaxent le soir ou avant de s'endormir après avoir fumé un joint et qui sont en meilleur état de travailler le lendemain, en sont autant d'exemples. Et ce ne sont pas des usagers exceptionnels.

D'autre part, l'économie souterraine des drogues, pas le trafic à grande échelle mais le trafic de fourmi dans des quartiers défavorisés ou même dans des milieux plus à l'aise, génère aussi des bénéfices économiques et une certaine capacité d'intégration sociale. Des familles entières dépendent des petits trafics de drogues. Des maisons et des voitures, des voyages et des vêtements de luxe, sont achetés « grâce » à la vente de drogues. Prenons un exemple concret : s'il est vrai que l'économie du cannabis seulement en Colombie-Britannique équivaut à 6 milliards $ par année, supposant qu'une partie importante de ces revenus – disons la moitié – reviennent à des personnes qui sont par ailleurs bien intégrés dans la société et n'appartiennent pas aux milieux criminalisés, c'est dire l'importance de la richesse générée par cette production.

---

[1] Pour une excellente discussion de ces analyses et de certaines des meilleures études menées en la matière, voir le rapport préparé par la Bibliothèque du Parlement pour le Comité : Jackson, A.Y. (2002) *Le coût de la consommation des drogues et la politique sur les drogues.* Ottawa : Bibliothèque du Parlement, rapport produit pour le Comité spécial du Sénat sur les drogues illicites, disponible en ligne à: www.parl.gc.ca/drogues-illicites.asp

[2] Single, E., et coll., (1996) *Les coûts de l'abus de substances au Canada : Une étude sur l'estimation des coûts.* Ottawa : Centre canadien de lutte contre l'alcoolisme et les toxicomanies.

L'analyse des coûts sociaux, basée sur le seul calcul des externalités, ne tient pas compte de l'économie de la drogue.

Finalement, ce type d'analyses repose sur une autre hypothèse, tout aussi difficile à défendre, selon laquelle les coûts sociaux induits par la consommation de drogues pourraient être investis ailleurs. C'est ce que la théorie économique appelle les coûts d'opportunité. Or, soit, comme dans le cas des coûts policiers, ils seraient vraisemblablement redistribués à l'intérieur de l'organisation, soit on ne peut tout simplement savoir quels autres coûts seraient occasionnés, par exemple, par la substitution à d'autres substances.

Ces précisions faites, l'étude de Single avait produit le tableau suivant[3] :

Les coûts totaux pour l'alcool, le tabac et les drogues illicites au Canada, 1992

	Alcool	Tabac	Drogues	Total
1. Coûts directs des soins de santé : total	**$1 300,6**	**$2 675,5**	**$88,0**	**$4 064,1**
1.1 la morbidité-hôpitaux de soins généraux	666,0	1 752,9	34,0	2 452,9
- hôpitaux psychiatriques	29,0	--	4,3	33,3
1.2 co-morbidité	72,0	--	4,7	76,7
1.3 service d'ambulance	21,8	57,2	1,1	80,1
1.4 soins à domicile	180,9	--	20,9	201,8
1.5 traitement externe	82,1	--	7,9	90,0
1.6 soins ambulatoires : honoraires des médecins	127,4	339,6	8,0	475,0
1.7 médicaments prescrits	95,5	457,3	5,8	558,5
1.8 autres coûts pour les soins de santé	26,0	68,4	1,3	95,8
2. Pertes directes associées au milieu de travail	**14,2**	**0,4**	**5,5**	**20,1**
2.1 PAE et programme de promotion de la santé	14,2	0,4	3,5	18,1
2.2 dépistage de consommation de drogues en milieu de travail	N/A	--	2,0	2,0
3. Coûts administratifs directs pour les transferts de paiements	**52,3**	**--**	**1,5**	**53,8**
3.1 allocations de bien-être et autres programmes	3,6	--	N/A	3,6
3.2 compensation des travailleurs	48,7	--	1,5	50,2
3.3 autres coûts administratifs	N/A	N/A	N/A	N/A
4. Coûts directs pour la prévention et la recherche	**141,4**	**48,0**	**41,9**	**231,1**
4.1 recherche	21,6	34,6	5,0	61,1

[3] Single, E. et.coll., (1996) *op. cit.*

	Alcool	Tabac	Drogues	Total
4.2 programmes de prévention	118,9	13,4	36,7	168,9
4.3 coûts de formation pour les médecins et les infirmières	0,9	N/A	0,2	1,1
4.4 coûts pour la modification de comportement	N/A	N/A	N/A	N/A
5. Coûts directs de l'application des lois	**1 359,1**	**--**	**400,3**	**1 759,4**
5.1 policiers	665,4	N/A	208,3	873,7
5.2 tribunaux	304,4	N/A	59,2	363,6
5.3 services correctionnels incluant la probation	389,3	N/A	123,8	513,1
5.4 douanes et accises	N/A	N/A	9,0	9,0
6. Autres coûts directs	**518,0**	**17,1**	**10,7**	**545,8**
6.1 dommage dû aux incendies	35,2	17,1	N/A	52,3
6.2 dommage dû aux accidents de la circulation	482,8	--	10,7	493,5
7. Coûts indirects : perte de productivité	**4 136,5**	**6 818,8**	**823,1**	**11 778,4**
7.1 perte de productivité due à la morbidité	1 397,7	84,5	275,7	1 757,9
7.2 perte de productivité due à la mortalité	2 738,8	6 734,3	547,4	10 020,5
7.3 perte de productivité due au crime	--	--	N/A	N/A
Total	**7 522,1**	**9 559,8**	**1 371,0**	**18 452,9**
Total du % du Produit intérieur brut	*1,09%*	*1,39%*	*0,20%*	*2,67%*
Total per capita	*$265*	*$336*	*$48*	*$649*
Total du % de tous les coûts reliés aux substances	*40,8%*	*51,8%*	*7,4%*	*100,0%*

L'examen de ces données révèle notamment ce qui suit :

- Les coûts de toutes les drogues illicites représentaient en 1992 près de 1,4 milliards $ comparativement à 7,5 milliards $ pour l'alcool et 9,6 milliards $ pour le tabac.
- Exprimés en pourcentage du produit intérieur brut, la totalité des substances représentait 2,67 % du PIB, soit 0,2 % pour les drogues illicites, 1,09 % pour l'alcool et 1,39 % pour le tabac.
- Le coût principal des drogues illicites correspond aux externalités, c'est-à-dire les pertes de productivité (823 millions $), les soins de santé (88 millions $), les pertes en milieu de travail (5,5 millions $) soit au total environ 67 % des coûts relatifs aux drogues illicites ;
- Les coûts des politiques publiques, ou coûts d'opportunité, représentent environ 33 %.

- Les coûts d'application de la loi représentent 29,2 % de tous les coûts, soit environ 88 % de tous les coûts de politique, le reste étant consacré à la prévention et à la recherche ainsi qu'à l'administration.

Notons que des études antérieures sur les coûts engendrés par les drogues illicites, menées en Colombie-Britannique (1991), Ontario (1988) et au Québec (1988), utilisant des méthodologies différentes, avaient établi des coûts respectivement de l'ordre de 388 millions $, 1,2 milliard $ et 2 milliards $, soit 3,5 milliards $ pour ces seules trois provinces.[4] On voit à quel point ces estimations peuvent être variables, selon les choix méthodologiques qui sont faits et la disponibilité des données.

Quoiqu'il en soit, et prenant le standard de l'étude du CCLAT, deux commentaires s'imposent. Premièrement, en ce qui concerne les pertes de productivité, qui est le principal élément de coût, elles sont calculées en mortalité (547 millions $) et morbidité (275 millions $). Le cannabis n'est pas – sauf lorsqu'il y a accidents de la route – une cause de mortalité ; en ce sens, le cannabis n'entraîne pas ce type de coût social. La morbidité correspond aux pertes imputables aux difficultés générées par la consommation de drogues qui se traduisent en différence entre le revenu annuel moyen des usagers et celui de la population en général. Deux observations ici relativement au cannabis : une part importante des usagers sont des jeunes qui ne travaillent pas encore ; et d'autre part, le cannabis n'entraîne pas les mêmes problèmes de dépendances que l'héroïne ou la cocaïne avec les troubles conséquents. Il est donc vraisemblable que la part qu'on pourrait imputer au cannabis à cet égard est minime. Selon toute vraisemblance, si l'on suit le mode de calcul des auteurs, **le cannabis en soi entraîne peu d'externalités**, qui sont par ailleurs le principal poste de coûts sociaux des drogues illicites.

Toutefois, il convient de noter que l'étude n'a pas calculé les coûts relatifs à la criminalité reliée aux substances. On sait que l'alcool est associé fréquemment aux délits de violence (au moins dans 30 % des cas) ainsi qu'aux délits de conduite avec facultés affaiblies qui occasionnent des pertes sociales et économiques importantes. En ce qui concerne les drogues illicites, la criminalité est de plusieurs types : évidemment, les réseaux de criminalité organisée ; ensuite les délits contre la propriété commis pour payer le coût des substances, ce qui s'applique essentiellement à l'héroïne et à la cocaïne ; enfin des délits contre les personnes (agressions) commis sous l'influence d'une drogue. À l'exception de la criminalité organisée et de la conduite sous l'influence d'une drogue, le cannabis entre très peu dans les facteurs générant la délinquance.

Deuxième observation. Après les pertes de productivité, le coût principal pour les drogues illicites dans l'étude de Single est celui de l'application de la loi qu'ils estimaient à environ 400 millions $. Nous avons déjà mentionné aux chapitres 14 et 15 que les coûts policiers et de la justice sont sûrement plus élevés et qu'ils totalisent

[4] Single, E. et coll., *op.cit*, page 15.

vraisemblablement entre 1 et 1,5 milliard $ au total. Comme le disent Single et coll., ce sont des coûts «[traduction] *qui relèvent d'une décision consciente de la part des décideurs politiques, contrairement aux coûts imposés aux systèmes de soin et à l'industrie du fait de la mortalité et de la morbidité induites par la consommation de drogues.* »[5] Quelle est la proportion reliée au cannabis ? Impossible de le savoir évidemment. Mais dans la mesure où 77 % de tous les délits relatifs aux drogues concernent le cannabis, où 50 % des délits relatifs aux drogues sont pour possession simple, tenant compte du fait qu'une proportion d'environ 60 % des incidents donneraient lieu à une mise en accusation, et qu'entre 10 % à 15 % des accusés recevraient une sentence d'incarcération, c'est dire qu'une proportion importante de l'activité du système de justice pénale en matière de drogues concerne les délits de cannabis. Il est permis de penser, mais nous admettons que ce n'est qu'une estimation grossière, que 30 % de toute l'activité du système de justice pénale porterait sur le cannabis. Sur la base de notre estimation la plus basse des coûts de l'application de la loi, soit 1 milliard $, c'est donc environ 300 millions $ par an que coûterait l'application des lois sur le cannabis.

En somme, les principaux coûts sociaux relatifs au cannabis relèvent de choix de politiques publiques, principalement de la criminalisation continue de cette substance, tandis que les conséquences de l'usage de la substance elle-même ne comptent que pour une fraction de l'ensemble des coûts sociaux imputables à l'usage de drogues illicites.

Quant aux coûts de la prévention et de la recherche, ils pâlissent à côté. Single les estimait à environ 42 millions $ en 1992. C'était à l'époque où la deuxième phase de la Stratégie canadienne sur les drogues battait son plein. Stratégie dont nous avons vu qu'elle n'a plus été financée depuis 1997. Il y a fort à parier que les dépenses de prévention et de recherche, loin d'avoir augmenté, ont probablement diminué tant au total des dépenses que proportionnellement aux coûts sociaux des drogues.

À diverses reprises au cours de notre rapport, nous avons parlé du Centre canadien de lutte contre l'alcoolisme et les toxicomanies, mentionnant tantôt son manque de visibilité et de légitimité, tantôt son manque de ressources – l'un et l'autre étant reliés. Si les coûts économiques et sociaux des drogues illicites « seulement » sont de l'ordre de 1,5 milliard $, ce qui est certainement un plancher considérant notre estimation des coûts de la seule répression, le budget annuel du CCLAT ne représente que 0,1 % de ces coûts ! Quand on sait que cet organisme est censé faciliter précisément tout ce que nous venons d'observer, en plus que d'être un lieu de connaissance et de dissémination des bonnes pratiques, il y a de quoi se demander si les gouvernements successifs ont été un tant soit peu sérieux. Et encore, nous n'avons même pas inclus dans ce calcul les coûts de l'alcool qui fait partie du champ de travail du CCLAT, et dont on sait qu'ils sont au moins 7 fois plus élevés que ceux des drogues illicites ! C'est pourquoi il est impératif de ramener cette proportion à 1 %, ce qui ne représente jamais qu'une dépense annuelle de 15 millions $ pour le gouvernement

---

[5] Single, E. et coll., (1996) *op. cit.*, page 57.

fédéral, une goutte d'eau dans l'océan, mais susceptible de générer des bénéfices incomparables.

CONCLUSIONS

Conclusions du chapitre 18	
Articulation des paliers	➢ L'absence d'une véritable plate-forme nationale de débats et d'échanges sur les drogues illicites ne permet pas l'élaboration d'objectifs clairs ni d'indicateurs de mesure. ➢ L'absence d'une plate-forme nationale ne permet pas l'échange de connaissances et de bonnes pratiques. ➢ Les pratiques et approches varient considérablement entre les provinces et territoires et à l'intérieur d'eux.
Arrimage des approches	➢ Les contradictions entre les approches des divers acteurs sur le terrain sont source de confusion. ➢ Les ressources et le pouvoir du domaine de l'application de la loi sont trop importants par rapport à ceux des domaines de la santé, de l'éducation et de la société civile.
Coûts du cannabis	➢ Les coûts pour l'ensemble des drogues illicites s'élevaient à près de 1,4 milliards $ en 1992. ➢ Les coûts évalués à l'époque correspondaient pour 67 % aux externalités (coûts sociaux) et pour 33 % aux coûts de mise en oeuvre des politiques publiques. ➢ Il s'agit selon nous d'une sous-estimation des coûts des drogues illicites, tant des coûts de mise en oeuvre des politiques publiques que des coûts sociaux. ➢ Nous estimons que les coûts de l'application de la loi (policiers, judiciaires et correctionnels) sur les drogues sont de l'ordre de 1 à 1,5 milliard $ par année. ➢ Le principal coût de mise en œuvre des politiques publiques relativement au cannabis porte sur l'application de la loi et le système de justice ; nous l'estimons à une somme variant entre 300 et 500 millions $ par année. ➢ Les coûts du cannabis en externalités sont vraisemblablement minimes (pas de mortalité, peu d'hospitalisations et peu de pertes de productivité imputables au cannabis). ➢ Les coûts de mise en oeuvre des politiques publiques relatives au cannabis sont démesurément élevés comparativement aux conséquences sociales et sanitaires de cette substance.

Sous-financement du Centre canadien de lutte contre l'alcoolisme et les toxicomanie	➢ **Le Centre canadien de lutte contre l'alcoolisme et les toxicomanies est sous-financé, et son budget annuel ne correspond qu'à 0,1 % des coûts sociaux des drogues illicites seulement (excluant l'alcool). Il faut porter ce budget à au moins 1 % soit environ 15 millions $ annuellement.**

M95

VOLUME

VOLUME

3

Micromedia
ProQuest

20 Victoria Street
Toronto, Ontario M5C 2N8
Tel.: (416) 362-5211
Toll Free: 1-800-387-2689
Fax: (416) 362-6161
Email: info@micromedia.on.ca

Senate Sénat

CANADA

CANNABIS :

OUR POSITION FOR A CANADIAN PUBLIC POLICY

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

VOLUME III : PART IV AND CONCLUSIONS

CHAIRMAN

PIERRE CLAUDE NOLIN

DEPUTY CHAIRMAN

COLIN KENNY

SEPTEMBER 2002

TABLE OF CONTENTS

INTRODUCTION 1

PART I - GENERAL ORIENTATION 5

CHAPTER 1 - OUR MANDATE 7
WORDING 7
ORIGINS 9
INTERPRETATION 10

CHAPTER 2 - OUR WORK 13
TWO WORKING PRINCIPLES 14
STATE OF KNOWLEDGE 15
Research Program 18
Expert Witnesses 19
The Challenge of Synthesis 21
TAKING OPINIONS INTO ACCOUNT 22
INTERPRETING IN LIGHT OF PRINCIPLES 23

CHAPTER 3 - OUR GUIDING PRINCIPLES 25
ETHICS, OR THE PRINCIPLE OF RECIPROCAL AUTONOMY 28
GOVERNANCE: MAXIMIZING THE ACTIONS OF INDIVIDUALS 32
Collective governance 34
Governance of the self 35
The role of governance 37
CRIMINAL LAW AND THE LIMITS OF PROHIBITION 38
Requirement for distinctions 38
Criteria for distinction 40
Application to illegal drugs issues 44
SCIENCE OR APPROXIMATE KNOWLEDGE 45
CONCLUSIONS 49

CHAPTER 4 - A CHANGING CONTEXT 51
CHANGES IN THE INTERNATIONAL SPHERE 51
Globalization and Integration 51
Difficulties of the Security Debate 55
From Anti-Drug Policies to Drug Policies 57
CHANGES IN CANADA 58
Judicial Activism 58
A National Crime Prevention Strategy 59
The Fight Against Organized Crime 59
A SOCIETAL DEBATE 60

PART II - CANNABIS: EFFECTS, TYPES OF USE, ATTITUDES 63

CHAPTER 5 - CANNABIS : FROM PLANT TO JOINT 65
ONE PLANT, VARIOUS DRUGS 66
CANNABIS ROADS 69
PROPERTIES OF CANNABIS 77
Δ^9THC Concentrations 78
Pharmacokinetics 83
CONCLUSIONS 87

CHAPTER 6 - USERS AND USES : FORM, PRACTICE, CONTEXT 89
PATTERNS OF USE 90
Consumption by the population as a whole 91
Consumption among young people 94
Use patterns in other countries 101
To summarize 108
PATTERNS AND CIRCUMSTANCES OF USE 111
Cannabis in History 111
Trajectories of Use 113
Factors Related to Use 119
To summarize 124
STEPPING STONE TOWARDS OTHER DRUGS? 125
CANNABIS, VIOLENCE AND CRIME 127
CONCLUSIONS 128

CHAPTER 7 - CANNABIS : EFFECTS AND CONSEQUENCES 131
EFFECTS AND CONSEQUENCES OF CANNABIS: WHAT WE WERE TOLD 134
ACUTE EFFECTS OF CANNABIS 139
CONSEQUENCES OF CHRONIC USE 143
Physiological Consequences of Chronic Use 143
Cognitive and Psychological Consequences 148
Behavioural and Social Consequences 152
TOLERANCE AND DEPENDENCE 152
Cannabis Dependence 154
Severity of Dependence 160
Tolerance 162
To summarize 163
CONCLUSIONS 164

CHAPTER 8 - DRIVING UNDER THE INFLUENCE OF CANNABIS 167
FORMS OF TESTING 170
EPIDEMIOLOGICAL DATA 175
Studies not involving accidents 175
Studies where an accident was involved 176
Epidemiological studies on youth 179

Risk assessment 180
EXPERIMENTAL STUDIES 182
Non-driving activities 183
While driving 184
CONCLUSIONS 188

CHAPTER 9 - USE OF MARIJUANA FOR THERAPEUTIC PURPOSES 191
HISTORY 196
CONTEMPORARY KNOWLEDGE 197
Therapeutic uses 198
Marijuana as a drug? 200
CURRENT THERAPEUTIC PRACTICES 203
CONCLUSIONS 205

CHAPTER 10 - CANADIANS' OPINIONS AND ATTITUDES 209
THE MEDIA 210
SURVEYS 215
ATTITUDES AND OPINIONS SHARED WITH THE COMMITTEE 221
CONCLUSIONS 224

PART III - POLICIES AND PRACTICES IN CANADA 225

CHAPTER 11 - A NATIONAL DRUG STRATEGY? 227
PHASE I - DEVELOPMENT AND IMPLEMENTATION 228
Creation of the Canadian Centre on Substance Abuse 233
Creation of Canada's Drug Strategy Secretariat 236
PHASE II - RENEWAL 237
PHASE III – RENEWAL WITHOUT SPECIFIED FUNDING 240
CANADA'S DRUG STRATEGY – A SUCCESS? 241
CONCLUSIONS 243

CHAPTER 12 - THE NATIONAL LEGISLATIVE CONTEXT 245
1908-1960: HYSTERIA 248
Opium Act, 1908 252
The Opium and Narcotic Drug Act, 1911 253
Amendments to the Opium and Narcotic Drug Act (1920-1938) 255
Amendments to the Act to Amend the Opium and Narcotic Drug Act in 1954 263
Senate Report of 1955 264
FROM 1960 TO THE LE DAIN COMMISSION: THE SEARCH FOR REASONS 268
Narcotic Control Act (1961) 268
An Act respecting Food and Drugs and Barbiturates (1961) 270
The Le Dain Commission (1969-1973) 272
Bill S-19 and Cannabis 283
AFTER LE DAIN: FORGING AHEAD REGARDLESS 284
Controlled Drugs and Substances Act 286
CONCLUSIONS 295

CHAPTER 13 - REGULATING THERAPEUTIC USE OF CANNABIS **297**
BACKGROUND TO THE RECENT REGULATIONS 298
Section 56 – Controlled Drugs and Substances Act 298
Charter Challenges – Therapeutic Use of Marijuana 299
Government Reaction 302
MARIHUANA MEDICAL ACCESS REGULATIONS 302
Authorization to Possess 303
Licence to Produce 306
Other Provisions 307
COMPASSIONATE ACCESS? 308
Eligibility 309
Access to cannabis 312
Products 316
Costs 316
RESEARCH PLAN 317
Scientific Research 318
Research-Grade Marijuana 320
CONCLUSIONS 321

CHAPTER 14 - POLICE PRACTICES **323**
ENFORCEMENT AGENCIES 323
RCMP 323
CHARGES UNDER THE CONTROLLED DRUGS AND SUBSTANCES ACT IN 1999 326
TheCanada Customs and Revenue Agency 326
Provincial and Municipal Police 328
COSTS 328
POLICE POWERS 333
Searches and Seizures 335
Entrapment and Illegal Activity 347
Conclusion 352
STATISTICS 353
Reported Incidents 353
Charges 356
Concerns 359
Customs Act - Fines 361
SEIZURES 362
CONCLUSIONS 364

CHAPTER 15 - THE CRIMINAL JUSTICE SYSTEM **367**
PROSECUTION 367
COURTS 368
Drug Treatment Courts 369
DISPOSITION AND SENTENCING 372
CORRECTIONS 376
CRIMINAL RECORD 379
COURT CHALLENGES 382
CONCLUSIONS 387

CHAPTER 16 - PREVENTION **389**
INITIATIVES THAT FALL SHORT OF THE MARK 393
Not enough prevention 394
Prevention lacks focus 396
There is not enough evaluation of preventive measures 397
Preventive and social messages in contradiction 398
There is a body of knowledge on which we have to draw 399
PREVENTING WHAT AND HOW? 400
RISK REDUCTION AND HARM REDUCTION 410
CONCLUSIONS 412

CHAPTER 17 - TREATMENT PRACTICES **415**
CANNABIS DEPENDENCY 415
FORMS OF TREATMENT 421
EFFECTIVENESS OF TREATMENT 423
CONCLUSIONS 426

CHAPTER 18 - OBSERVATIONS ON PRACTICES **427**
DIFFICULTIES IN HARMONIZING THE PLAYERS 427
INCONGRUITIES OF APPROACH 429
SIGNIFICANT ECONOMIC AND SOCIAL COSTS 431

PART IV - PUBLIC POLICY OPTIONS **437**

CHAPTER 19 - THE INTERNATIONAL LEGAL ENVIRONMENT **439**
A GENEALOGY **440**
The 1909 Shanghai Conference **443**
The 1912 Hague International Opium Convention **444**
The 1925 Geneva Opium Conventions **446**
The 1931 Geneva Narcotics Manufacturing and Distribution Limitation Convention / 1931 Bangkok Opium Smoking Agreement **447**
The 1936 Geneva Convention for the Suppression of the Illicit Traffic in Dangerous Drugs **448**
The Second World War **449**
The 1946 Lake Success Protocol **449**
The 1948 Paris Protocol **450**
The 1953 New York Opium Protocol **450**
THE THREE CURRENT CONVENTIONS **451**
The Single Convention on Narcotic Drugs, 1961 **451**
Convention on Psychotropic Substances **455**
Protocol amending the Single Convention on Narcotic Drugs, 1961 **460**
Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances **462**
SOME LEEWAY? **464**
CONCLUSIONS **468**

CHAPTER 20 - PUBLIC POLICIES IN OTHER COUNTRIES 469
FRANCE 470
Different Forms of Logic 470
An Integrated Public Policy 472
Legislative Framework 474
Key Reports 477
Statistics on Use and Offences 481
Costs 483
THE NETHERLANDS 485
Dutch Pragmatism? 486
Essential Experts Reports 488
Legislation 493
The Coffee Shop System 496
Data on Use 498
UNITED KINGDOM 502
Ten-Year Strategy to Battle Drugs 502
Legislative Framework 503
Other Relevant Legislation in the Field of Drug Misuse 505
Debate in the UK 506
Recent Key Reports and Studies 507
Administration 515
Costs 515
Statistics 516
SWEDEN 518
National Strategy 520
Legislative Framework 523
Debate in Sweden 525
Recent Reports 526
Costs 528
Administration 528
Statistics 529
SWITZERLAND 531
A Harm Reduction Policy 531
The Legal Framework 538
A Bill to Decriminalize Cannabis 539
Administration of Swiss Drug Policy 542
Statistics on Narcotics Use and Offences under the Narcotics Act 544
AUSTRALIA 546
National Drug Strategy 546
Legislative Framework 551
Decriminilization in Australia 554
Administration 556
Statistics 557
UNITED STATES 560
The Federal-State Legislative Framework 560
Current Legislation and Enforcement 563
Federal Drug Policy Goals and Objectives 570
Administration of the Policy 572
Current Issues and Debates 575

Statistics 576

CHAPTER 21 - PUBLIC POLICY OPTIONS 581
INEFFECTIVENESS OF CRIMINAL POLICIES 583
Impact on Consumption 583
Impact on Supply 589
Conclusion 590
GENERAL ECONOMY OF A PUBLIC POLICY ON CANNABIS 591
COMPONENTS OF A PUBLIC POLICY 593
Strong Decision-making Body 593
Interconnection 594
A Shared Definition of Shared Objectives 594
Information Tools 594
LEGISLATIVE OPTIONS 595
Clarification of criminology 595
Criteria for a Legal Policy on Cannabis 602

CONCLUSIONS AND RECOMMENDATIONS 607

LE DAIN – ALREADY THIRTY YEARS AGO 607
INEFFECTIVENESS OF THE CURRENT APPROACH 609
PUBLIC POLICY BASED ON GUIDING PRINCIPLES 610
A CLEAR AND COHERENT FEDERAL STRATEGY 611
NATIONAL STRATEGY SUSTAINED BY ADEQUATE RESOURCES AND TOOLS 612
A PUBLIC HEALTH POLICY 614
A REGULATORY APPROACH TO CANNABIS 617
A COMPASSION-BASED APPROACH FOR THERAPEUTIC USE 618
PROVISIONS FOR OPERATING A VEHICLE UNDER THE INFLUENCE OF CANNABIS 619
RESEARCH 620
CANADA'S INTERNATIONAL POSITION 621

PROPOSALS FOR IMPLEMENTING THE REGULATION OF CANNABIS FOR THERAPEUTIC AND RECREATIONAL PURPOSES 623

BIBLIOGRAPHY 627

GLOSSARY OF KEY TERMS

Abuse
Vague term with a variety of meanings depending on the social, medical and legal contexts. Some equate any use of illicit drugs to abuse: for example, the international conventions consider that any use of drugs other than for medical or scientific purposes is abuse. The Diagnosis and Statistical Manual of the American Psychiatric Association defines abuse as a maladaptive pattern of substance use leading to clinically significant impairment or distress as defined by one or more of four criteria (see chapter 7). In the report, we prefer the term excessive use (or harmful use).

Acute effects
Refers to effects resulting from the administration of any drug and specifically to its short term effects. These effects are distinguished between central (cerebral functions) and peripheral (nervous system). Effects are dose-related.

Addiction
General term referring to the concepts of tolerance and dependency. According to WHO addiction is the repeated use of a psychoactive substance to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance, has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain the substance by almost any means. Some authors prefer the term addiction to dependence, because the former also refers to the evolutive process preceding dependence. (toxicomanie a de l'information additionelle)

Agonist
A substance that acts on receptor sites to produce certain responses.

Anandamide
Agonist neurotransmitter of the endogenous cannabinoid system. Although not yet fully understood in research, these neurotransmitters seem to act as modulators, THC increasing the liberation of dopamine in nucleus accumbens and cerebral cortex.

At-risk use
Use behaviour which makes users at-risk of developing dependence to the substance.

Cannabinoids
Endogenous receptors of the active cannabis molecules, particularly 9-THC. Two endogenous receptors have been identified: CB1 densely concentrated in the hippacampus, basal ganglia, cerebellum and cerebral cortex, and CB2, particularly abundant in the immune system. The central effects of cannabis appear to be related only to CB1.

Cannabis
Three varieties of the cannabis plant exist: *cannabis sativa*, *cannabis indica*, and *cannabis ruredalis*. *Cannabis sativa* is the most commonly found, growing in almost any soil condition. The cannabis plant has been known in China for about 6000 years. The flowering tops and leaves are used to produce the smoked cannabis. Common terms used to refer to cannabis are pot, marihuana, dope, ganja, hemp. Hashish is produced from the extracted resin. Classified as a psychotropic

drug, cannabis is a modulator of the central nervous system. It contains over 460 known chemicals, of which 60 are cannabinoids. Delta-9-tétrahydrocannabinol, referred to as THC, is the principal active ingredient of cannabis. Other components such delta-8-tétrahydrocannabinol, cannabinol and cannabidiol are present in smaller quantities and have no significant impacts on behaviour or perception. However, they may modulate the overall effects of the substance.

Chronic effects
Refers to effects which are delayed or develop after repeated use. In the report we prefer to use the term consequences of repeated use rather than chronic effects.

Commission on narcotic drugs (CND)
The Commission on Narcotic Drugs (CND) was established in 1946 by the Economic and Social Council of the United Nations. It is the central policy-making body within the UN system for dealing with all drug-related matters. The Commission analyses the world drug abuse situation and develops proposals to strengthen international drug control.

Decriminalization
Removal of a behaviour or activity from the scope of the criminal justice system. A distinction is usually made between *de jure decriminalization*, which entails an amendment to criminal legislation, and *de facto decriminalization*, which involves an administrative decision not to prosecute acts that nonetheless remain against the law. Decriminalization concerns only criminal legislation, and does not mean that the legal system has no further jurisdiction of any kind in this regard: other, non-criminal, laws may regulate the behaviour or activity that has been decriminalized (civil or regulatory offences, etc.).

Diversion
The use of measures other than prosecution or a criminal conviction for an act that nonetheless remains against the law. Diversion can take place before a charge is formally laid, for example if the accused person agrees to undergo treatment. It can also occur at the time of sentencing, when community service or treatment may be imposed rather than incarceration.

Depenalisation
Modification of the sentences provided in criminal legislation for a particular behaviour In the case of cannabis, it generally refers to the removal of custodial sentences.

Dependence
State where the user continues its use of the substance despite significant health, psychological, relational, familial or social problems. Dependence is a complex phenomenon which may have genetic components. Psychological dependence refers to the psychological symptoms associated with craving and physical dependence to tolerance and the adaptation of the organism to chronic use. The American Psychiatric Association has proposed seven criteria (see chapter 7).

Dopamine
Neuromediator involved in the mechanisms of pleasure.

Drug
Generally used to refer to illicit rather than licit substances (such as nicotine, alcohol or medicines). In pharmacology, the term refers to any chemical agent that alters the biochemical

or physiological processes of tissues or organisms. In this sense, the term drug refers better to any substance which is principally used for its psychoactive effects.

European Monitoring Centre on Drugs and Drug Addiction (EMCDDA)
The European Monitoring Centre was created in 1993 to provide member states objective, reliable and comparable information within the EU on drugs, drug addictions and their consequences. Statistical information, documents and techniques developed in the EMCDDA are designed to give a broad perspective on drug issues in Europe. The Centre only deals with information. It relies on national focal points in each of the Member States.

Fat soluble
Characteristic of a substance to irrigate quickly the tissues. THC is highly fat-soluble.

Gateway (theory)
Theory suggesting a sequential pattern in involvement in drug use from nicotine to alcohol, to cannabis and then "hard" drugs. The theory rests on a statistical association between the use of hard drugs and the fact that these users have generally used cannabis as their first illicit drug. This theory has not been validated by empirical research and is considered outdated.

Half-life
Time needed for the concentration of a particular drug in blood to decline to half its maximum level. The half-life of THC is 4.3 days on average but is faster in regular than in occasional users. Because it is highly fat soluble, THC is stored in fatty tissues, thus increasing its half life to as much as 7 to 12 days. Prolonged use of cannabis increases the period of time needed to eliminate is from the system. Even one week after use, THC metabolites may remain in the system. They are gradually metabolised in the urine (one third) and in feces (two thirds). Traces on inactive THC metabolites can be detected as many as 30 days after use.

Hashish
Resinous extract from the flowering tops of the cannabis plant and transformed into a paste.

International Conventions
Various international conventions have been adopted by the international community since 1912, first under the Society of Nations and then under the United Nations, to regulate the possession, use, production, distribution, sale, etc., of various psychotropic substances. Currently, the three main conventions are the 1961 Single Convention, the 1971 Convention on Psychotropic Substance and the 1988 Convention against Illicit Traffic. Canada is a signatory to all three conventions. Subject to countries' national constitutions, these conventions establish a system of regulation where only medical and scientific uses are permitted. This system is based on the prohibition of source plants (coca, opium and cannabis) and the regulation of synthetic chemicals produced by pharmaceutical companies.

International Narcotics Control Board (INCB)
The Board is an independent, quasi-judicial organisation responsible for monitoring the implementation of the UN conventions on drugs. It was created in 1968 as a follow up to the 1961 Single Convention, but had predecessors as early as the 1930s. The Board makes recommendations to the UN Commission on Narcotics with respect to additions or deletions in the appendices of the conventions.

Intoxication
Disturbance of the physiological and psychological systems resulting from a substance. Pharmacology generally distinguishes four levels: light, moderate, serious and fatal.

Joint
Cigarette of marijuana or hashish with or without tobacco. Because joints are never identical, scientific analyses of the effects of THC are more difficult, especially in trying to determine the therapeutic benefits of cannabis and to examine its effects on driving.

Legalisation
Regulatory system allowing the culture, production, marketing, sale and use of substances. Although none currently exist in relation to «street-drugs» (as opposed to alcohol or tobacco which are regulated products), a legalisation system could take two forms: without any state control (free markets) and with state controls (regulatory regime).

Marijuana
Mexican term originally referring to a cigarette of poor quality. Has now become equivalent for cannabis.

Narcotic
Substance which can induce stupor or artificial sleep. Usually restricted to designate opiates. Sometimes used incorrectly to refer to all drugs capable of inducing dependence.

Office of national drug control policy (ONDCP) USA
Created in 1984 under the Reagan presidency, the Office is under the direct authority of the White House. It coordinates US policy on drugs. Its budget is currently US $18 billion.

Opiates
Substance derived from the opium poppy. The term opiate excludes synthetic opioids such as heroin and methadone.

Prohibition
Historically, the term designates the period of national interdiction of alcohol sales in the United States between 1919 and 1933. By analogy, the term is now used to describe UN and State policies aiming for a drug-free society. Prohibition is based on the interdiction to cultivate, produce, fabricate, sell, possess, use, etc., some substances except for medical and scientific purposes.

Psychoactive substance
Substance which alters mental processes such as thinking or emotions. More neutral than the term "drug" because it does not refer to the legal status of the substance, it is the term we prefer to use.

Psychotropic substance (see also psychoactive)
Much the same as psychoactive substance. More specifically however, the term refers to drugs primarily used in the treatment of mental disorders, such as anxiolytic, sedatives, neuroleptics, etc. More specifically, refers to the substances covered in the 1971 Convention on Psychotropic Substances.

Regulation
Control system specifying the conditions under which the cultivation, production, marketing, prescription, sales, possession or use of a substance are allowed. Regulatory approaches may rest on interdiction (as for illegal drugs) or controlled access (as for medical drugs or alcohol). Our proposal of an exemption regime under the current legislation is a regulatory regime.

Society of Nations (SDN)
International organisation of States until 1938; now the United Nations.

Tetrahydrocannabinol (Δ9-THC)
Main active component of cannabis, Δ9-THC is very fat-soluble and has a lengthy half-life. Its psychoactive effects are modulated by other active components in cannabis. In its natural state, cannabis contains between 0.5% to 5% THC. Sophisticated cultivation methods and plant selection, especially female plants, leads to higher levels of THC concentration.

Tolerance
Reduced response of the organisms and increased capacity to support its effects after a more or less lengthy period of use. Tolerance levels are extremely variable between substances, and tolerance to cannabis is believed to be lower than for most other drugs, including tobacco and alcohol.

Toxicity
Characteristic of a substance which induces intoxication, i.e., "poisoning". Many substances, including some common foods, have some level of toxicity. Cannabis presents almost no toxicity and cannot lead to an overdose.

United Nations Drug Control Program (UNDCP)
Established in 1991, the Programme works to educate the world about the dangers of drug abuse. The Programme aims to strengthen international action against drug production, trafficking and drug-related crime through alternative development projects, crop monitoring and anti-money laundering programmes. UNDCP also provides accurate statistics through the Global Assessment Programme (GAP) and helps to draft legislation and train judicial officials as part of its Legal Assistance Programme. UNDCP is part of the UN Office for Drug Control and the Prevention of Crime.

World Health Organization (WHO)
The World Health Organization, the United Nations specialized agency for health, was established on 7 April 1948. WHO's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health. Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

PART IV

PUBLIC POLICY OPTIONS

CHAPTER 19

THE INTERNATIONAL LEGAL ENVIRONMENT

This chapter could begin and end with the same words: The international drug control conventions are, with respect to cannabis at least, an utterly irrational restraint that has nothing to do with scientific or public health considerations.

Very useful restraint, to be sure, if one favours prohibition, for when the advocates of such policy run out of scientific and public health arguments, they can simply fall back on the conventions that Canada has signed. More than signed, in fact: owing to the efforts of certain men, police officers and federal public servants, Canada was a leading proponent of those conventions.

Currently, three conventions govern the entire life cycle of drugs, from cultivation of the plants to their consumption: the *Single Convention on Narcotic Drugs, 1961* (Single Convention),[1] the 1971 *Convention on Psychotropic Substances* (Psychotropics Convention)[2] and the 1988 *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (Trafficking Convention).[3] They create not only international law concerning drugs but also control mechanisms and bodies, both political and bureaucratic.

Yet these agreements have a history that began well before the Single Convention, a history that sheds light on the issues that led to their development and on their contemporary significance. That is the subject of the first section. The conventions create obligations, as shown in the second section, detailed obligations that are morally rather than legally binding. And they are a patchwork of compromises that leave states with some leeway, as we shall see in the third section.

---

[1] Single Convention on Narcotic Drugs, 1961 (RTC 1964/30), amended by the Protocol amending the Single Convention on Narcotic Drugs, 1961 (RTC 1976/48). The Single Convention came into force in Canada in 1964 and the Protocol in 1976.

[2] Convention on Psychotropic Substances, RTC 1988/35. It came into force in Canada in 1988.

[3] Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, RTC 1990/42, which came into force in Canada in 1990.

A GENEALOGY

The genealogy of the international conventions governing drug production and trade is fascinating and unique. The story begins in the mid-19th century, when Britain and China fought two opium wars, both quickly won by the British. In this era, the roles were reversed: the British owned the lucrative opium monopoly of the East India Company and refused to relinquish it, while the Chinese had been trying for decades to stamp out opium use, not so much for health reasons as for economic ones, since this trade was exacting a heavy toll.

> *China had long exercised the upper hand in its economic relations with the Occident. Silks, teas, fine pottery, and other items flowed west. Yet the Middle Kingdom desired little from the outside. (...) Encouraging the China opium trade therefore solved several related problems for colonial governments. Opium production provided a living for numerous peasants, merchants, bankers, and governments officials. Exports to China earned hard currency, thereby reducing specie outflow.* [4]

While Britain balked at introducing control mechanisms that would deprive it of hard currency, the United States realized at the turn of the century that this was a perfect opportunity to assert itself on the international scene.

The drug story's geopolitical ingredients blended with well-known domestic political interests, racist attitudes and economic interests in a complex cocktail. In Chapters 11 and 12, we touched on certain aspects of the anti-Chinese racism that marked the turn of the century in Canada. The same phenomenon existed in the U.S.

> [Translation] *The United States had a number of reasons for acting on this proposal. The official reason was a moral one: at a time when the temperance leagues and the churches were demanding Prohibition, puritan America decided to take the lead in civilization's world crusade. It claimed to be protecting uncivilized races from the ravages of opium and alcohol. But it also had some less virtuous reasons. Under pressure from the trade unions, which feared competition from Chinese labour, it passed the Exclusion Laws, openly xenophobic legislation whose purpose was to control the yellow peril. It therefore spread the myth of the 'unsavoury Chinese opium addict,' devoted to his habit and ready to contaminate American youth.* [5]

Naturally, the Chinese government vigorously protested against the Exclusion Laws, but the Middle Kingdom, a victim of its conflicts and its internal disorganization, lacked the resources to make an impact on the international scene. While continuing to combat opium use within its own territory, China set about promoting poppy cultivation at the local level.

---

[4] McAllister, W.B., (1999) *Drug Diplomacy in the Twentieth Century. An international history*, pages 10-11.

[5] Caballero, F., and Y. Bisiou (2000) *Droit de la drogue*. Paris: Dalloz, 2nd edition, page 36.

The pharmaceutical industry, which had been booming since the mid-19th century, was able to produce more and more low-priced medicines, many of which contained extracts of coca or opium.

> *The mid-1880s euphoric reaction of cocaine set off a chain reaction. Pharmaceutical companies rushed to fill orders, but fresh coca leaf was unavailable in sufficient quantity. Consequently, the price skyrocketed. To meet demand and share in the profit, several imperial powers stepped up efforts to develop commercially saleable coca. (...) Within a few years, coca production increased dramatically, coca paste processing became commonplace, coca leaves became a commodity traded on the international market and pharmaceutical manufacturers competed for business on the basis of price, availability, and quality of product. Hardly available in 1885, cocaine became quickly emblematic of the modern, technological, international, political economy. (...) By the early twentieth century, cocaine ranked third in terms of dollar value among drugs. The popularity of the two drugs superseding cocaine, morphine and quinine, resulted from the same constellation of factors – a burgeoning pharmaco-industrial complex.* [6]

The third factor was the growing professionalism and social power of the medical community. The latter was essentially working against a form of popular medicine, ostensibly because it was a source of abuse and charlatanism, but mostly because it was practised outside the medical establishment and thus was less tightly controlled by scholarly medical "authority". Certain of its science, the powerful medical lobby would quickly swing into action and demand the regulation of drugs and sole authority to diagnose and prescribe.

Last but not least, there were moral considerations. The temperance movements fighting the moral and social "vices" of alcohol and drugs were growing rapidly and carried substantial political clout, which the prohibitionists wielded brilliantly.

The last piece of the puzzle was the 1906 decision by Britain's new Liberal government to oppose the forced opium trade between India and China, which made it possible for the Chinese government to launch an extensive campaign against opium consumption and production. In 1907, the British agreed to reduce exports of Indian opium to China by 10 per cent a year, provided that China would permit independent verification of its own production cuts. The accord proved more effective than the two countries expected, until the Manchu (Ch'ing) dynasty fell in 1911. After that, the Chinese warlords began encouraging opium production on a large scale to finance their military spending. Nevertheless, future prohibition advocates would view the 1907 "ten-year agreement" as the first successful opium "treaty"; for the next 60 years. This agreement was to set the tone for international drug control negotiations.[7] The stage was now set for the first in a long series of international conferences, treaties and conventions, as shown in the table below.[8]

---

[6] McAllister, *op. cit.*, pages 15-16.

[7] McAllister, *op. cit.*, pages 24-27.

[8] This table and the text of this section are taken from the excellent report prepared by the Library of Parliament at the Committee's request: Sinha, J. (2001) *The History and Development of the Leading*

Multilateral Agreements on Narcotics and Psychotropic Substances[9]

Date and place signed	*Title of agreement*	*Date of entry into force*
26 February 1909 Shanghai, China	Final Resolutions of the International Opium Commission [1]	Not applicable
23 January 1912 The Hague, Netherlands	International Opium Convention	11 February 1915 / 28 June 1919 [2]
11 February 1925 Geneva, Switzerland	Agreement concerning the Manufacture of, Internal Trade in, and Use of Prepared Opium	28 July 1926
19 February 1925 Geneva, Switzerland	International Opium Convention	25 September 1928
13 July 1931 Geneva, Switzerland	Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs [3]	9 July 1933
27 November 1931 Bangkok, Thailand	Agreement for the Control of Opium Smoking in the Far East	22 April 1937
26 June 1936 Geneva, Switzerland	Convention for the Suppression of the Illicit Traffic in Dangerous Drugs	26 October 1939
11 December 1946 Lake Success, New York, USA	Protocol amending the Agreements, Conventions and Protocols on Narcotic Drugs concluded at The Hague on 23 January 1912, at Geneva on 11 February 1925 and 19 February 1925 and 13 July 1931, at Bangkok on 27 November 1931, and at Geneva on 26 June 1936	11 December 1946
19 November 1948 Paris, France	Protocol Bringing under International Control Drugs outside the Scope of the Convention of 13 July 1931, for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, as amended by the Protocol signed at Lake Success, New York, on 11 December 1946	1 December 1949
23 June 1953 New York, USA	Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of, Opium	8 March 1963
30 March 1961 New York, USA.	Single Convention on Narcotic Drugs, 1961	13 December 1964
21 February 1971 Vienna, Austria	Convention on Psychotropic Substances	16 August 1976
25 March 1972 Geneva, Switzerland	Protocol amending the Single Convention on Narcotic Drugs, 1961	8 August 1975
20 December 1988 Vienna, Austria	United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances	11 November 1990

[1] This is the only document in the table that is not an enforceable multilateral treaty. It is included because it marks the beginning of substantial international cooperation on drug control.
[2] China, the Netherlands, and the U.S. implemented the Convention in 1915 (Honduras and Norway followed suit later that year). It did not come into force globally until it was incorporated into the Treaty of Versailles in 1919.
[3] As amended by the Protocol signed at Lake Success, New York, on 11 December 1946.

International Drug Control Conventions. Ottawa: Library of Parliament, Parliamentary Research Branch, available on the Committee's Web site at www.parl.gc.ca/illegal-drugs.asp .

[9] Sources: Canadian Treaty Series; Kettil Bruun, Lynn Pan and Ingemar Rexed, (1975) *The Gentlemen's Club: International Control of Drugs and Alcohol*, Chicago: University of Chicago Press; United States, (1972) *International Narcotics Control: A Source Book of Conventions, Protocols, and Multilateral Agreements, 1909-1971*, Washington, D.C.: Bureau of Narcotics & Dangerous Drugs.

The 1909 Shanghai Conference

U.S. interest in international drug control grew substantially following the Spanish-American War, which led to its acquisition of the Philippines in 1898.[10] The acquisition brought with it what the American administration perceived as a serious problem: a government-run opium supply monopoly. Under the guidance of the new Episcopal Bishop of the Philippines, Charles Henry Brent, the monopoly was shut down. Yet smuggling continued, and Brent, who regarded the opium issue as a moral question and use of the drug as *"a social vice … a crime,"* persuaded President Theodore Roosevelt to support holding an international meeting in Shanghai to remedy what was clearly a regional problem.[11]

In February 1909, the International Opium Commission[12] met in Shanghai, with Brent as its president. However, because the participants did not have the necessary plenipotentiary powers to conclude a treaty, the result was simply a collection of facts and a set of non-binding recommendations. In the discussions on the Commission's terms of reference, one question that arose was whether drug-related medical issues, such as addiction and its treatment, should be considered; the proposal was defeated (by a majority of one) because it was felt that there was insufficient medical expertise present at the meeting.[13] This set a telling precedent: most subsequent drug meetings would be attended predominantly by diplomats and civil servants, with little significant input from medical experts.

The negotiations during the Commission's meetings laid the groundwork for future conferences. The U.S., aggressively represented by Hamilton Wright, tried to persuade the colonial powers to support a narrow definition of "legitimate use" of opium, under which any non-medical or non-scientific use–by Western medical and scientific standards–would be considered illicit. The colonial powers advocated a softer approach, which would permit "quasi-medical use". In the final wording of Resolution 3, the Commission concluded "that the use of opium in any form otherwise than for medical purposes is *held* by *almost* every participating country to be a matter for prohibition *or for careful regulation*; and that each country in the administration of its system or regulation purports to be aiming, as opportunity offers, at progressively increasing stringency" (emphasis as in original).

The Commission was, in fact, far from "international". The focus was on China's opium problems–five of the nine resolutions mentioned China by name–and the U.S. and Britain dominated the discussions. The U.S. was pushing for prohibition and felt that China needed assistance with its domestic opium problems. Britain worked to

---

[10] Lowes, P.D. (1966) *The Genesis of International Narcotics Control.* Geneva: Droz, page 102.

[11] Bewley-Taylor, D.R. (1999) *The United States and International Drug Control.* page 19.

[12] The Commission included all the colonial powers in the region – Britain, France, Germany, Japan, the Netherlands, Portugal and Russia – and China, Siam [now Thailand], Persia [now Iran], Italy and Austria-Hungary. (McAllister (2000), page 28)

[13] Bruun *et al.* (1975), page 11; Lowes (1966), page 187-188.

protect its lucrative Indian opium trade, arguing that curbing such trade would be useless until China brought its domestic production under control.[14]

Underlying the U.S. delegation's hard-line stance at the Shanghai meeting were key domestic political and economic goals that would also colour later negotiations. It was assumed that if other countries controlled their own opium production and exports, the U.S. would not be burdened with the task, because the poppy and the coca leaf had never been grown in appreciable quantities in North America. Furthermore, international agreements calling on countries to take drastic internal measures provided ammunition for Brent and Wright, who were pressuring the U.S. government to develop stringent domestic drug control laws.[15]

The 1912 Hague International Opium Convention

At the Shanghai meeting, the Americans had proposed a future conference to draft an international drug control treaty that would include the Shanghai resolutions in an expanded and more stringent form. This proposal was contested by the other countries and went nowhere. In the years that followed, however, the U.S. lobbied continually and forcefully around the world for a new conference. Addressing the opium problem directly, publicly and internationally was a way for the U.S. to achieve its domestic control objectives, to put an end to the profitable drug trade dominated by the colonial powers, and to curry favour with the Chinese and thereby improve Sino-American economic relations.[16]

Twelve countries agreed to meet at The Hague on 1 December 1911 to draft a treaty.[17] Once again, the meeting was chaired by Brent, and Wright led the U.S. delegation. Most states had demanded amendments to the U.S. draft agenda, which focused on stringent control of opium production, manufacture and distribution in Asia. For example, Britain insisted that manufactured drugs such as morphine, heroin, and cocaine be considered. This was an attempt to dilute the opium agenda and deflect attention from Indian opium production. Britain also hoped that a fair treaty would create a level playing field for British pharmaceutical companies to compete with the dominant German synthetic drug industry.[18]

---

[14] Walker III, William O., (1991) *Opium and Foreign Policy: The Anglo-American Search for Order in Asia, 1912-1954*, Chapel Hill, N.C.: University of North Carolina Press, page 16-17; Lowes (1966), page 152-153.

[15] Musto (1999), page 36-37.

[16] William B. McAllister, (1992) "Conflicts of Interest in the International Drug Control System," in William O. Walker III, ed., *Drug Control Policy: Essays in Historical and Comparative Perspective*, University Park, Pennsylvania: Pennsylvania State University Press, page 145.

[17] Germany, China, the United States, France, Britain, the Netherlands, Italy, Japan, Persia [now Iran], Portugal, Russia and Siam [now Thailand].

[18] McAllister (2000), page 32-33; Bruun *et al.* (1975), page 11-12.

Chapters I and II of the 1912 *International Opium Convention*[19] (1912 Hague Convention) dealt with raw and prepared opium. For example, Article 1 required parties to "enact effective laws or regulations for the control of the production and distribution of raw opium" unless such laws were already in place. The Convention also recognized the U.S.-initiated principle of restricting opium use to medical and scientific purposes. Chapter IV was aimed at reducing drug trafficking in China.

Chapter III focused on licensing, manufacturing and distribution controls on synthetic drugs, but Germany ensured that the provisions were weak and vague. Article 10 allowed countries to simply make their *"best endeavours"* to implement these controls. Furthermore, Germany refused to sign the treaty until it was agreed that all countries would have to ratify[20] the Convention before it came into force. This was an effective tactic for delaying control measures as it took almost a decade for all countries to ratify the agreement. Germany did so only because ratification was a condition of the Treaty of Versailles that ended the First World War in 1919.[21]

Wright used the 1912 Hague Convention in his campaign for U.S. domestic legislation, arguing that a federal law was necessary for the U.S. to fulfil its obligations under the Convention. In 1916, the U.S. Supreme Court ruled that this was not so, but by then the *Harrison Narcotics Act of 1914* had become the first federal drug control law in the U.S.; it would remain a pillar of U.S. drug policy for the next few decades.[22]

The establishment of the League of Nations in 1919 following the First World War provided the international community with a centralized body for the administration of drug control. In 1920, the League created the Advisory Committee on the Traffic in Opium and other Dangerous Drugs, commonly known as the Opium Advisory Committee (OAC), the precursor to the United Nations (UN) Commission on Narcotic Drugs. The League Health Committee, forerunner of the UN World Health Organization, was also formed. Administration of the 1912 Hague Convention had originally been the responsibility of the Netherlands, but was transferred to the Opium Control Board (OCB) created by the OAC. Enforcement of the Convention was sporadic as the countries on the OCB were the ones profiting most from the drug trade.[23]

The League began to consider demand-side socio-medical issues such as why individuals use drugs, what constitutes drug abuse, and what social factors affect abuse.

[19] Done 23 January 1912; in force 28 June 1919.

[20] Ratification is the process by which each country enacts national implementing legislation – unless the new international obligations are already met by domestic legislation – and thereby consents to the treaty's application within its territory.

[21] McAllister (2000), page 36-37; Bruun *et al.* (1975), page 12; Lowes (1966), page 182-186.

[22] Musto (1999), page 59-63. Since the U.S. Constitution did not allow a direct federal role in criminalizing drug use, Wright designed the *Harrison Act* as a tax statute; physicians, pharmacists, wholesalers and retailers had to obtain a tax stamp to distribute drugs. The Treasury Department was responsible for enforcing the statute. Thus, the use of drugs was limited through access restrictions. (McAllister (2000), page 35)

[23] McAllister (1992), page 145-146.

However, prohibition and supply-side issues soon regained the ascendancy as preparations began and talks were held, again at the instance of the U.S., for a new treaty in the mid-1920s. In general, the international regime has tended to separate the study of drug-related medical and social problems, including etiological questions, from that of drug control problems.[24]

The 1925 Geneva Opium Conventions

Even though the U.S. had chosen not to join the League of Nations, its influence in international drug control matters remained strong. Worried by the 1912 Hague Convention's limited effect on the smuggling of opium and, increasingly, drugs manufactured in East Asia, the U.S. pressured the League to convene a new conference. The League feared that if it did not comply, the U.S. might act independently.[25]

Between November 1924 and February 1925, two back-to-back conferences were held, and two separate treaties were concluded. The first Geneva Convention[26] focused on opium-producing nations; signatories were permitted to sell opium only through government-run monopolies and were required to end the trade completely within 15 years.

The second Geneva Convention, the *International Opium Convention*[27] (1925 Geneva Convention), was intended to impose global controls over a wider range of drugs, **including, for the first time, cannabis**, which was referred to as "Indian hemp" (marijuana) in Article 11 of the Convention. Articles 21 to 23 required Parties to provide annual statistics on drug stocks and consumption; the production of raw opium and coca; and the manufacture and distribution of heroin, morphine and cocaine. Chapter VI replaced the OCB with an eight-member Permanent Central Opium Board (PCOB).[28] Chapter V of the second Convention set up a PCOB-monitored import certification system to control the international drug trade by limiting the amount that each country could legally import.

While the 1912 Hague Convention had focused on domestic controls, the Geneva Conventions were an attempt to improve transnational control. The U.S. had proposed strict adherence to the principle that drugs should be used only for medical and scientific purposes and that there should be stringent controls on drug production at the source. When these proposals were flatly rejected at the second conference, the U.S.

---

[24] McAllister (2000), page 46-50; Lowes (1966), page 188.

[25] McAllister (2000), page 50-51.

[26] *Agreement concerning the Manufacture of, Internal Trade in, and Use of Prepared Opium*, done 11 February 1925, in force 28 July 1926.

[27] Done 19 February 1925; in force 25 September 1928.

[28] The PCOB was intended to be impartial and politically disinterested, but its operations remain extremely political to this day (it still exists). Since its inception, its membership has always included a representative from Britain, the U.S. and France. (McAllister (2000), page 83)

delegation walked out of the conference and never signed the treaties. The Chinese delegation withdrew as well, because no agreement could be reached on the suppression of opium smoking.[29] Instead, the two countries concentrated on enforcing the 1912 Hague Convention.

The 1931 Geneva Narcotics Manufacturing and Distribution Limitation Convention / 1931 Bangkok Opium Smoking Agreement

The import control system put in place following the 1925 Geneva Convention was only partially effective, as drugs were simply transhipped through non-signatory countries. In 1931, the League of Nations convened a further conference in Geneva to place limits on the manufacture of cocaine, heroin and morphine, and to control their distribution. The result of the conference was the *Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs*[30] (1931 Limitation Convention).

In 1931, Canada abandoned its policy of simply reacting to international drug control efforts and began playing an active role in supporting U.S. efforts to expand control at the source. Colonel Charles Henry Ludovic Sharman, Chief of the Narcotics Division in the Department of Pensions and National Health, was the principal architect of Canada's domestic and international drug policy until the 1960s. Canada, through Sharman, was heavily involved in the negotiations leading up to the 1931 Limitation Convention.[31]

A new player also emerged from within the U.S. delegation: Harry J. Anslinger, first Commissioner of the newly created Federal Bureau of Narcotics, a position he would hold for 33 years. A firm believer in prohibition and the control of drug supplies at the source, Anslinger is widely recognized as a prime mover in the development of U.S. drug policy and, by extension, international drug control into the early 1970s.[32]

The centrepiece of the 1931 Limitation Convention was the manufacturing limitation system set out in Chapters II and III. Parties were required to provide the PCOB with estimates of their national drug requirements for medical and scientific purposes, and on the basis of those estimates, the PCOB would calculate manufacturing limits for each signatory. A Drug Supervisory Body (DSB) was created to administer the system. The Convention's effectiveness was seriously undermined by Article 26, which absolved states of any responsibilities under the Convention for their

[29] Bruun *et al.* (1975), page 14.

[30] Done 13 July 1931; in force 9 July 1933.

[31] Giffen *et al.* (2000), page 483.

[32] See, for example, McAllister (2000), page 89-90; Bewley-Taylor (1999), page 102-164; Bruun *et al.* (1975), page 137-141; Inglis (1975), page 181-190. See also Harry J. Anslinger and Will Oursler, "The War against the Murderers," in William O. Walker III, ed., *Drugs in the Western Hemisphere: An Odyssey of Cultures in Conflict*, Wilmington, Delaware: Scholarly Resources Inc., 1996.

colonies. Article 15 required states to set up a "special administration" for national drug control, modelled to some extent on the U.S. domestic control apparatus.[33]

The Convention came into force quickly because various countries and the League of Nations thought it might provide a useful model for arms control negotiations. The League even prepared a report explaining how the principles set out in the 1925 Geneva Convention and the Limitation Convention could be applied to disarmament issues.[34]

In late 1931, another conference was held in Bangkok to address opium smoking in the Far East. The treaty[35] it produced was weak, primarily because the U.S. attended only as an observer and the European colonial powers were unwilling to implement effective controls on opium use while there was significant opium overproduction and smuggling. The fact that the U.S. strategy of absolute prohibition had made little impact on opium trafficking and use in the Philippines did not strengthen the U.S.'s hand in pushing for the elimination of poppy cultivation. The key result of the Bangkok conference was that it convinced the U.S. that a firmer approach was needed to combat raw material production and illicit drug trafficking.[36]

The 1936 Geneva Convention for the Suppression of the Illicit Traffic in Dangerous Drugs

Based on initiatives of the International Police Commission, forerunner of the International Criminal Police Organization (INTERPOL), negotiations had begun in 1930 to develop a treaty to stem illicit drug trafficking and punish traffickers severely through criminal sanctions.[37]

In 1936, the *Convention for the Suppression of the Illicit Traffic in Dangerous Drugs*[38] (1936 Trafficking Convention) was concluded in Geneva. The U.S., led by Anslinger, had attempted to include provisions that would criminalize all activities–cultivation, production, manufacture and distribution–related to the use of opium, coca (and its derivatives) and cannabis for non-medical and non-scientific purposes. Many countries objected to this proposal, and the focus remained on illicit trafficking.[39] Article 2 of the Convention called on signatory countries to use their national criminal law systems to "severely" punish, "particularly by imprisonment or other penalties of deprivation of liberty," acts directly related to drug trafficking.

---

[33] Anslinger would use this provision continually in the future as a way of protecting his position and the Federal Bureau of Narcotics from being altered through reorganization. (McAllister (2000), page 98, 108-109)

[34] *Ibid.*, page 110-111.

[35] *Agreement for the Control of Opium Smoking in the Far East*, done 27 November 1931, in force 22 April 1937.

[36] Taylor (1969), page 275-279; McAllister (2000), page 106.

[37] Taylor (1969), page 288-298.

[38] Done 26 June 1936; in force 26 October 1939.

[39] Taylor (1969), page 293-295.

The U.S. refused to sign the final version because it considered the Convention too weak, especially in relation to extradition, extraterritoriality and the confiscation of trafficking revenues. The U.S. was also worried that if it signed, it might have to weaken its domestic criminal control system to comply with the Convention. In fact, the Convention never gained widespread acceptance, as most countries interested in targeting traffickers concluded their own bilateral treaties.

Despite its minimal overall effect, the 1936 Trafficking Convention marked a turning point. All the previous treaties had dealt with the regulation of "legitimate" drug activities, whereas the 1936 Trafficking Convention now made such activities an international crime subject to penal sanctions.

The Second World War

In the late 1930s, the Opium Advisory Committee (OAC) of the League of Nations began to question the international drug control regime's emphasis on prohibition and law enforcement. Some countries proposed combating abuse through public health approaches, including psychological treatment, dispensary clinics and educational programs. Asserting the U.S. belief that addicts could only be cured through institutionalization, Anslinger, supported by Sharman, was able to block all OAC efforts to consider social and etiological approaches to drug problems. Instead, at Anslinger's insistence, the focus remained on developing a new treaty to impose prohibition and supply control worldwide.[40]

Ironically, in anticipation of war, many countries (in particular the U.S.) built up stockpiles of opium and opium products intended for medical purposes.[41] The Second World War put further development of the international drug control apparatus on hold.

The 1946 Lake Success Protocol

Following the war, the drug control bodies and functions of the League of Nations were folded into the newly formed United Nations.[42] The UN Economic and Social Council (ECOSOC) took over primary responsibility through its Commission on Narcotic Drugs (CND), which replaced the OAC. Under the CND, the Division of Narcotic Drugs (DND) was charged with the preparatory work for conferences. The PCOB and the DSB continued under the CND in their respective roles of compiling

---

[40] McAllister (2000), page 126-127.

[41] The possibility of war accentuated the hypocrisy and opportunistic nature of the U.S. prohibitionist position. In 1939, Anslinger "was simultaneously pursuing a League-sponsored treaty to curtail agricultural production in far-off lands, a regional agreement that would allow him to commence poppy cultivation at home, and a global acquisition program that amassed the world's largest cache of licit opium yet assembled." (McAllister (2000), page 133)

[42] See Bewley-Taylor (1999), page 54-59; Bruun *et al.* (1975), page 54-65.

statistics for national estimates and administering previous treaties. Canada's Sharman became the first Chair of the CND and also held a seat on the DSB.

All these changes in responsibility and organization meant that the existing international drug control treaties had to be amended. The amendments were made in a Protocol[43] signed at Lake Success, New York, on 110 December 1946.

The 1948 Paris Protocol

Anslinger and Sharman campaigned hard to ensure that the CND would report directly to ECOSOC as an independent organization. They were afraid that if the main drug control apparatus was a larger health or social issues organization, such as the World Health Organization (WHO) or the United Nations Educational, Scientific and Cultural Organization (UNESCO), etiology and treatment issues might take precedence over the prohibition focus. In particular, they wanted to ensure that governments would be represented by law enforcement officials rather than physicians or others with sociology or public health backgrounds. Furthermore, the USSR showed interest in considering the social factors underlying drug abuse. For the Western powers to have agreed with the Soviet Union would have undermined their hard-line stance against Moscow and communism in the looming Cold War.

Although control remained principally with ECOSOC, the World Health Organization (WHO), in particular its Drug Dependence Expert Committee, became responsible for deciding what substances should be regulated.[44] This authority was given to the WHO in an international Protocol[45] signed in Paris in 1948. Article 1 stated that if the WHO found a drug to be *"capable of producing addiction or of conversion into a product capable of producing addiction,"* it would decide how to classify the drug within the international drug control structure. The Protocol also brought under international control specific synthetic opiates not covered by previous treaties.

The 1953 New York Opium Protocol

By the late 1940s, it became clear that the large number of international drug treaties, with their differing types and levels of control, had become confusing and unwieldy. Anslinger, Sharman and their allies had the CND recommend to ECOSOC the idea of consolidating all existing treaties into one document. It would also be an

---

[43] *Protocol amending the Agreements, Conventions and Protocols on Narcotic Drugs concluded at The Hague on 23 January 1912, at Geneva on 11 February 1925 and 19 February 1925 and 13 July 1931, at Bangkok on 27 November 1931, and at Geneva on 26 June 1936*, done 11 December 1946, in force 11 December 1946.

[44] Bruun *et al.* (1975), page 70.

[45] *Protocol Bringing under International Control Drugs outside the Scope of the Convention of 13 July 1931, for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, as amended by the Protocol signed at Lake Success, New York, on 11 December 1946*, done 19 November 1948, in force 1 December 1949.

opportunity to bring in more stringent prohibition-based controls.[46] This plan was sidelined for a decade when the Director of the DND, Leon Steinig, proposed the creation of an "International Opium Monopoly" in an attempt to end the illicit trade and guarantee wholesale licit opium supply.

Throughout the 1950s, Cold War tensions pushed Anslinger to rebuild the U.S. stockpile of opium and opium derivatives, often by making large purchases from Iran through U.S. pharmaceutical companies. Many European countries were also stockpiling. The multinational pharmaceutical companies in Europe and the U.S. feared that a monopoly like the one proposed by Steinig would lead to restrictions and higher prices. Anslinger and Sharman along with the British, Dutch and French killed the monopoly discussions in the CND. The French representative on the CND, Charles Vaille, suggested a new opium protocol as an interim solution until the treaties could be consolidated. ECOSOC approved a plenipotentiary conference, and Anslinger seized the new protocol initiative as an opportunity to impose strict global controls on opium production.[47]

The Protocol[48] (1953 Opium Protocol), finalized in New York in 1953, Article 2 stated bluntly that Parties were required *to "limit the use of opium exclusively to medical and scientific needs."* Various provisions were included to control the cultivation of the poppy and the production and distribution of opium. Article 6 restricted opium production to seven states, and Parties could only import or export opium produced in one of those countries.[49] The Protocol comprised the most stringent international drug control provisions yet, but it never gained the support Anslinger had hoped for. It did not receive sufficient ratifications to bring it into force until 1963, and by then it had been superseded by the 1961 Single Convention.

THE THREE CURRENT CONVENTIONS

The Single Convention on Narcotic Drugs, 1961

The Single Convention has played a central role in the creation of the modern prohibitionist system of international drug control. It is a continuation and expansion of the legal infrastructure developed between 1909 and 1953.

The work of consolidating the existing international drug control treaties into one instrument began in 1948, but it was 1961 before an acceptable third draft was ready to

---

[46] ECOSOC approved the recommendation in two resolutions: 159 II D (VII) of 3 August 1948, and 246 D (IX) of 6 July 1949. See also McAllister (2000), page 172; Bewley-Taylor (1999), page 137.

[47] McAllister (2000), page 172-179.

[48] *Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of, Opium*, done 23 June 1953, in force 8 March 1963.

[49] The seven producing countries were Bulgaria, Greece, India, Iran, Turkey, the USSR and Yugoslavia.

be presented for discussion at a plenipotentiary conference.[50] The conference began in New York on 24 January 1961, and was attended by 73 countries, each "with an agenda based on its own domestic priorities."[51]

William B. McAllister has divided the participating states into five distinct categories based on their drug control stance and objectives.

- Organic states group: *As producers of the organic raw materials for most of the global drug supply, these countries had been the traditional focus of international drug control efforts. They were open to socio-cultural drug use, having lived with it for centuries. While India, Turkey, Pakistan and Burma took the lead, the group also included the coca-producing states of Indonesia and the Andean region of South America, the opium- and cannabis-producing countries of South and Southeast Asia, and the cannabis-producing states in the Horn of Africa. They favoured weak controls because existing restrictions on production and export had directly affected large segments of their domestic population and industry. They supported national control efforts based on local conditions and were wary of strong international control bodies under the UN. Although essentially powerless to fight the prohibition philosophy directly, they effectively forced a compromise by working together to dilute the treaty language with exceptions, loopholes and deferrals. They also sought development aid to compensate for losses caused by strict controls.*

- Manufacturing states group: *This group included primarily Western industrialized nations, the key players being the U.S., Britain, Canada, Switzerland, the Netherlands, West Germany and Japan. Having no cultural affinity for organic drug use and being faced with the effects that drug abuse was having on their citizens, they advocated very stringent controls on the production of organic raw materials and on illicit trafficking. As the principal manufacturers of synthetic psychotropics, and backed by a determined industry lobby, they forcefully opposed undue restrictions on medical research or the production and distribution of manufactured drugs. They favoured strong supranational control bodies as long as they continued to exercise* de facto *control over such bodies. Their strategy was essentially to "shift as much of the regulatory burden as possible to the raw-material-producing states while retaining as much of their own freedom as possible."*

- Strict control group: *These were essentially non-producing and non-manufacturing states with no direct economic stake in the drug trade. The key members were France, Sweden, Brazil and Nationalist China. Most of the states in this group were culturally opposed to drug use and suffered from abuse problems. They favoured restricting drug use to medical and scientific purposes and were willing to sacrifice a degree of national sovereignty to ensure the effectiveness of supranational control bodies. They were forced to moderate their demands in order to secure the widest possible agreement.*

---

[50] One of the Canadian delegates to the CND, National Health and Welfare official Robert Curran, played the leading role in drafting a document that would be acceptable to all countries as a starting point for negotiations (McAllister (2000), page 205). For an analysis of this third draft, see Leland M. Goodrich, "New Trends in Narcotics Control", *International Conciliation*, No. 530, November 1960.

[51] McAllister (1992), page 148.

- Weak control group: *This group was led by the Soviet Union and often included its allies in Europe, Asia and Africa. They considered drug control a purely internal issue and adamantly opposed any intrusion on national sovereignty, such as independent inspections. With little interest in the drug trade and minimal domestic abuse problems, they refused to give any supranational body excessive power, especially over internal decision-making.*

- Neutral group: *This was a diverse group including most of the African countries, Central America, sub-Andean South America, Luxembourg and the Vatican. They had no strong interest in the issue apart from ensuring their own access to sufficient drug supplies. Some voted with political blocs, others were willing to trade votes, and others were truly neutral and could go either way on the control issue depending on the persuasive power of the arguments presented. In general, they supported compromise with a view to obtaining the broadest possible agreement.*

The result of all these competing interests was a document that epitomized compromise. The Single Convention clearly upheld and expanded existing controls and in its breadth was the most prohibitionist document yet concluded, though it was not as stringent as it might have been. It was free of the costly features of the 1953 Opium Protocol, such as the provision restricting opium production to the seven specified countries. Sharman no longer negotiated for Canada, and Anslinger had played a minor role in the conference owing to conflicts with the U.S. State Department. The latter was content with the Convention because U.S. influence was assured within the UN supervisory bodies and the prohibitive framework had been expanded to include tight controls over coca and cannabis. Since the U.S. originated the idea of the Single Convention, walking out of the conference would have meant losing face in the UN and given the impression of weakness vis-à-vis the Soviet Union during a tense Cold War period.[52]

The principal foundations of the previous treaties remained in place in the Single Convention.[53] Parties were still required to submit estimates of their drug requirements and statistical returns on the production, manufacture, use, consumption, import, export, and stockpiling of drugs.[54] The import certification system created by the 1925

---

[52] Anslinger was extremely disappointed with the Single Convention because he believed that the opium control provisions were not stringent enough (e.g., Article 25 still allowed any country to produce up to five tons of opium annually, albeit subject to strict controls). He attempted to derail the Convention by lobbying countries to ratify the 1953 Opium Protocol in hopes of obtaining the number of ratifications needed to bring it into force. He failed, and his influence waned after that. (Bewley-Taylor (1999), page 136-161)

[53] Only the 1936 Trafficking Convention was not included in the Single Convention and remained in force separately, because agreement could not be reached on which of its provisions should be included in the Single Convention (McAllister (2000), page 207-208). Article 35 of the Single Convention simply encouraged cooperation between countries to combat illicit trafficking.

[54] Single Convention, Articles 19 and 20.

Geneva Convention was maintained. Parties were required to license all manufacturers, traders and distributors, and all transactions involving drugs had to be documented.[55] The Single Convention built on the trend of requiring Parties to develop increasingly punitive criminal legislation. Subject to their constitutional limitations, Parties were to adopt distinct criminal offences, punishable preferably by imprisonment, for each of the following drug-related activities in contravention of the Convention: cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation.[56] Furthermore, the granting of extradition was described as "desirable."[57]

The Convention assigned substances to one of four schedules based on level of control. Schedules I and IV were the most stringent and covered primarily raw organic materials (opium, coca, cannabis) and their derivatives, such as heroin and cocaine. Schedules II and III were less strict and contained primarily codeine-based synthetic drugs. At the U.S.'s insistence, cannabis was placed under the heaviest control regime in the Convention, Schedule IV. This regime included drugs such as heroin (the WHO considered any medical use of heroin to be "obsolete"). The argument for placing cannabis in this category was that it was widely abused. The WHO later found that cannabis could have medical applications after all, but the structure was already in place and no international action has since been taken to correct this anomaly.

The U.S. was pleased with the Single Convention as it broadened control over cultivation of the opium poppy, coca bush and cannabis plant, though the measures were not as stringent as the ones Anslinger had negotiated in the 1953 Opium Protocol.[58] Articles 23 and 24 of the Convention set up national opium monopolies and put very strict limitations on international trade in opium.

Article 49 of the Convention required Parties to completely eliminate all quasi-medical use of opium,[59] opium smoking, coca leaf chewing, and non-medical cannabis use within 25 years of the coming into force of the Convention. All production or manufacture of these drugs was also to be eradicated within the same period. Only Parties for which such uses were "traditional" could take advantage of delayed implementation; for others, prohibition was immediate. Since the implementation period ended in 1989, these practices are today fully prohibited, and the drugs may be used only for regulated medical and scientific purposes.

Apart from consolidating the previous treaties and expanding control provisions, the Single Convention also streamlined the UN's drug-related supervisory bodies. The PCOB and the DSB were merged in a new body, the International Narcotics Control Board (INCB), responsible for monitoring application of the Convention and

[55] *Ibid.*, Articles 21 and 29-32.

[56] *Ibid.*, Article 36.

[57] *Ibid.*, Article 36(2).

[58] Single Convention, Articles 22-28.

[59] The limit was 15 years for the quasi-medical use of opium.

administering the system of estimates and statistical returns submitted annually by Parties.[60] The INCB was to have eleven members, three nominated by the WHO and eight by Parties to the Convention and UN members. The manufacturing lobby's effectiveness in the negotiations was evident in the knowledge requirement for WHO nominees: *"medical, pharmacological or pharmaceutical experience."*[61] The INCB was given a limited power of embargo: it could recommend that Parties stop international drug trade with any Party that failed to comply with the provisions of the Convention.[62]

The Convention's emphasis on prohibition was reflected in the minimal attention paid to drug abuse problems. Only Article 38 touched on the social (demand) side of the drug problem by requiring Parties to *"give special attention to the provision of facilities for the medical treatment, care and rehabilitation of drug addicts."* Furthermore, it was considered "desirable" that Parties "establish adequate facilities for the effective treatment of drug addicts," but only if the country had *"a serious problem of drug addiction and its economic resources [would] permit."* The inadequate recognition of demand/harm reduction approaches, such as prevention through education, has been one of the key criticisms of both the Single Convention and international drug control treaties in general.[63]

The Single Convention effectively consolidated several decades' worth of assorted drug control machinery into one key document administered by one principal body, the United Nations.

Convention on Psychotropic Substances

In the 1960s, following the signing of the Single Convention, drug use and abuse exploded around the world, especially in developed Western nations.[64] The increase was particularly evident in the pervasive use and availability of synthetic psychotropic substances developed since the Second World War, such as amphetamines, barbiturates and LSD. Most of these drugs were not subject to international control, and because national systems of regulation differed widely, trafficking and smuggling flourished.[65]

Throughout the 1960s, the CND and the WHO debated the issue of control of psychotropic drugs at regular meetings and made various recommendations to member

---

[60] Single Convention, Articles 5 and 9-16.

[61] *Ibid.*, Article 9(1)(a).

[62] *Ibid.*, Article 14(2).

[63] See, for example, *Report of the International Working Group on the Single Convention on Narcotic Drugs, 1961*, Toronto, Addiction Research Foundation, 1983, page 10-11; recommendations 4, 5, 15, 19 and 20.

[64] See, for example, Vladimir Kuševic, (1977) "Drug Abuse Control and International Treaties", *Journal of Drug Issues*, Vol. 7, No. 1, page 35-53. See also McAllister (2000), page 218-220; Musto (1999), ch. 11; McAllister (1992), page 153-162; Bruun *et al.* (1975), ch. 16; Inglis (1975), ch. 13.

[65] The U.S. attempted to regulate psychotropic substances through the Bureau of Drug Abuse Control, established under the *Drug Abuse Control Act of 1965*. This statute also shifted the constitutional basis for drug control from the taxing power to interstate and commerce powers, a change that led to the demise of Anslinger's Federal Bureau of Narcotics and the birth of the Bureau of Narcotics and Dangerous Drugs (BNDD) under the federal Department of Justice. (Musto (1999), page 239-240)

states concerning the national control of particular substances, including stimulants, sedatives and LSD. In January 1970, the CND discussed a draft treaty prepared by the UN Division of Narcotic Drugs on the international control of psychotropic drugs. Following some modifications by the CND, this document became the basis for negotiations at a plenipotentiary conference convened in Vienna on 11 July 1971; this conference produced the Psychotropics Convention.[66]

The 1961 Single Convention had been used as a template for the draft Psychotropics Convention, and many of the former's features are found in the latter: CND/INCB administrative authority, schedules establishing different levels of control for different drugs, mandatory transaction documentation and licensing, an import/export control system, illicit trafficking provisions and criminal sanctions. Though superficially quite similar, the two Conventions are in fact extremely different. The Psychotropics Convention imposes much weaker controls. The reason for this becomes apparent when the positions of the negotiating stakeholders are examined and selected parts of the two treaties are carefully compared.[67] The overwhelming influence of the multinational pharmaceutical industry on the Psychotropics Convention was particularly obvious.[68]

In contrast to the five negotiating groups identified by McAllister for the Single Convention, there were only two distinct blocs with conflicting positions at the Vienna conference. One group included mostly developed nations with powerful pharmaceutical industries and active psychotropics markets; this was essentially the "manufacturing group." The other group consisted of developing states, supported by the socialist countries, with few psychotropic manufacturing facilities; this was to a large extent the "organic group." At the 1971 negotiations, however, the positions of the two groups were *completely reversed.* The manufacturing group adopted the traditional arguments of the organic group: weak controls, national as opposed to international controls, and national sovereignty taking precedence over any supranational UN body. The rationale for these positions was that strict controls would be difficult to enforce and would cause financial loss. The organic group, on the other hand, pushed hard for strict controls similar to those it had been forced to accept in the Single Convention.[69]

---

[66] Kuševic (1975), page 38.

[67] McAllister (1992), page 154-162; Kuševic (1975), page 38-41. McAllister's comparison is highly detailed, and well worth reading; Kuševic provides useful background and commentary. See also S.K. Chatterjee (1988) *A Guide to the International Drugs Conventions*, London: Commonwealth Secretariat, page 15-33, for a more technical, lower-level comparison of the two Conventions.

[68] The lead author of the preliminary draft, Arthur Lande, had ended his career at the UN shortly before the Vienna conference. He attended the conference as representative of the U.S. Pharmaceutical Manufacturer's Association, one of many industry observers. Another example of the industry's blatant influence involved a group of six small Latin American countries. They uncharacteristically supported weakening the treaty and were all represented by a Swiss national who was not fluent in Spanish and was not a government official, a diplomat or a narcotics expert. He worked for the European pharmaceutical giant Hoffmann-LaRoche. (McAllister (2000), page 232; Kuševic (1975), page 39)

[69] McAllister (1992), page 154; Kuševic (1975), page 39.

A comparison of the Preambles of the two Conventions is revealing. Although the Preamble is not legally binding, it encapsulates the spirit of the instrument. In the Single Convention, addiction is described as *"a serious evil for the individual ... fraught with social and economic danger to mankind."* It is recognized, however, that *"the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes."* By contrast, the Psychotropics Convention makes no mention of the "serious evil" of "addiction," but rather notes *"with concern the public health and social problems resulting from the abuse of certain psychotropic substances."* As well, it is recognized that *"the use of psychotropic substances for medical and scientific purposes is indispensable and that their availability for such purposes should not be unduly restricted."* The overall tone of the Psychotropics Convention Preamble is less harsh, and it implies that *"abuse of certain," not all, psychotropics, is not as serious a problem as "addiction to narcotic drugs"* in general.

The approach to categorizing drugs by means of schedules with varying levels of control also differed between the two Conventions. In the 1961 Single Convention negotiations, when the placement of a drug in a particular schedule was disputed, the drug almost always ended up in a schedule not favoured by the organic group – for example, the placement of cannabis in Schedule IV. The manufacturing group's insistence on this classification method was based on the idea that narcotic drugs should be considered hazardous until proven otherwise. This reasoning did not apply, however, when U.S. economic interests were at stake. In 1971, the U.S. delegation argued forcefully and often successfully that organic raw materials should be assigned to the strictest schedules, while their manufactured derivatives should be placed in the weaker schedules.

The Psychotropics Convention also contains four schedules of control, but they are substantially different in nature and organization from those of the Single Convention. For example, the most stringent schedule in the Single Convention is Schedule IV,[70] which is equivalent to Schedule I[71] in the Psychotropics Convention. In both cases, the drugs included may be used only by authorized persons in government-operated medical or scientific institutions, and their manufacture, import and export are strictly controlled. The weakest schedule in the Psychotropics Convention is Schedule IV, which contains tranquilizers. Some manufacturing states tried to eliminate Schedule IV by arguing that such drugs were sufficiently regulated by national controls and that international control was therefore unnecessary. In the end, Schedule IV was retained, albeit with a much shorter list of drugs. However, the principle on which drugs were classified was completely reversed, in particular by the U.S.: *"unless there was substantial proof that a substance was harmful, it should remain uncontrolled."*[72]

---

[70] Which includes cannabis and heroin, for example.

[71] Which includes hallucinogens, such as LSD.

[72] McAllister (1992), page 158.

Another key difference between the two Conventions is revealed by a close comparison of the schedules. Previous treaties, including the Single Convention, not only covered the base substances but also extended control to include their salts, esters, ethers and isomers, i.e., their derivatives. In contrast, derivatives were *completely absent* from the schedules of the Psychotropics Convention. As a result, every substance to be covered under the treaty regime must be specified by name. In practical terms, that is impossible because new derivatives are constantly being produced, and they comprise 95 per cent of the substances developed by pharmaceutical firms. If a general reference to derivatives had been included, new substances would have been covered automatically. This omission was apparently the result of a deal made between political representatives when the technical experts were not present; the derivatives had to be sacrificed in order to get the manufacturing states to sign the treaty.[73]

The system of estimates set out in Article 19 of the Single Convention requires Parties to report annually to the INCB how much of each controlled substance they will need for the next year. This system is one of the pillars of the international drug control regime and dates back to the second Geneva conference, which led to the 1925 International Opium Convention. It was *completely excluded* from the Psychotropics Convention. As McAllister has pointed out, "*[t]his omission was clearly in the interests of the manufacturing states, because without estimates of need it is impossible to calculate whether more of a substance than can legitimately be put to use is being fabricated.*"[74] This allowed multinationals to manufacture unlimited quantities of psychotropic substances without being constrained by annual production limits based on licit need.

These omissions–derivatives and estimates–were largely corrected during the 1970s and 1980s through quiet recourse to customary international law by the DND and the INCB. The latter asked Parties to submit psychotropics information and statistics not required by the Convention. The initial positive responses from various organic group states were then used to persuade others to follow suit. Similarly, the CND and the WHO simply announced that derivatives would be included in the schedules. Some governments complied and others were eventually forced by international pressure to do likewise.

Article 3 of the Single Convention gives the WHO the key role in determining whether, on the basis of a medical or scientific analysis, a new drug should be added to a schedule and thus placed under international control. The WHO's recommendation is submitted to the CND, which makes the final decision. However, any Party may appeal the CND's decision to ECOSOC within 90 days. ECOSOC's decision is final. While a decision is being appealed, the CND may still require Parties to place control measures on the substance in question.

Under the Psychotropics Convention, the WHO continues to make recommendations based on medical and scientific criteria. However, Article 2(5)

---

73 McAllister (2000), page 233.
74 McAllister (1992), page 157.

explicitly directs the CND to bear in mind *"the economic, social, legal, administrative and other factors it may consider relevant"* in coming to its decision. Furthermore, Article 17(2) states that the CND's decision is subject to approval by a two-thirds majority of CND members.[75] The CND's decision may still be appealed to ECOSOC, and Parties have up to 180 days to do so. In addition, ECOSOC's decision is not necessarily final; there is the possibility of continual appeals. Lastly, while a decision is being appealed, Article 2(7) allows a Party to take "exceptional action" and exempt itself from certain control measures ordered by the CND pending the outcome of the appeal. The cumulative effect of all of these additions to the Psychotropics Convention is that it can be much harder for the WHO to bring a new psychotropic drug within the control system than to add a new narcotic drug to the Single Convention.

The criteria for placing a new drug under control also differ between the two Conventions. According to Article 3 of the Single Convention, a narcotic drug will come within the control regime if it is *"liable to similar abuse and productive of similar ill effects as the drugs"* in the relevant schedule. The prerequisites under Article 2(4) of the Psychotropics Convention are significantly more stringent. The WHO must find:

> *(a) that the substance has the capacity to produce*
> *(i) (1) a state of dependence, and*
> *(2) central nervous system stimulation or depression, resulting in hallucinations or disturbances in motor function or thinking or behaviour or perception or mood, or*
> *(ii) similar abuse and similar ill effects as a substance in Schedule I, II, III or IV, and*
> *that there is sufficient evidence that the substance is being or is likely to be abused so as to constitute a public health and social problem warranting the placing of the substance under international control.*

Taking the lead for the manufacturing group on this point, the U.S. and Britain were the most adamant about including such highly restrictive criteria.[76]

The Psychotropics Convention is far ahead of the Single Convention's superficial attempt to address the demand side of drug problems (Article 38 described above). Article 20 of the 1971 treaty is a milestone in that it introduced the concepts of public education and abuse prevention into the legal infrastructure of international drug control. In particular, it enjoins Parties to *"take all practical measures for the prevention of abuse of psychotropic substances and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved, and [to] coordinate their efforts to these ends."* Parties are also required to promote "as far as possible" the training of personnel to carry out these tasks and encouraged to further the study and public awareness of etiological issues related to abuse. Although these provisions leave plenty of room for countries to avoid taking measures, they are a definite improvement over the Single Convention.

---

[75] The U.S. tried to increase it to a three-quarters majority. (McAllister, 2000, page 161)
[76] *Ibid.*, page 159.

The penal provisions in Article 22 of the Psychotropics Convention allow states to use treatment, education, after-care, rehabilitation and social reintegration instead of just conviction or punishment in dealing with abusers who commit offences under the Convention. While the acknowledgement of treatment and rehabilitation is an improvement over previous strictly penal provisions, such measures are intended as a supplement to imprisonment rather than as an alternative.[77]

On the whole, the 1971 negotiations resulted in a treaty that was significantly weaker than the Single Convention. Furthermore, any possibility of revisiting the provisions of the Psychotropics Convention was not realistic in the early 1970s, as a new chapter in the U.S. "war on drugs" was beginning.[78]

Protocol amending the Single Convention on Narcotic Drugs, 1961

In the early 1970s, U.S. President Richard Nixon officially declared "war on drugs" in response to the massive drug abuse in the U.S. and the social damage it was causing. This announcement had global repercussions.[79]

In 1971, as part of the Nixon administration's international anti-narcotics campaign, U.S. officials suggested creating a government-funded, UN-administered fund to combat drug abuse.[80] The United Nations Fund for Drug Abuse Control (UNFDAC) was launched in 1971 with an initial $2 million donation from the U.S. Other governments were reluctant to contribute because of the motives behind the Fund. This reluctance was well founded as UNFDAC essentially became a U.S. tool.

---

77 United Nations, *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Done at Vienna on 20 December 1988*, New York: United Nations, 1976, page 353-354.

78 The U.S. war on drugs is considered to have begun with the enactment of a federal drug control law known as the *Harrison Narcotics Act of 1914*, and has continued ever since at varying levels of intensity. The most recent supporters of the war on drugs include President Nixon in the late 1960s and early 1970s, President Ronald Reagan in the 1980s, President George Bush in the late 1980s and early 1990s, President Bill Clinton in the 1990s and now President George W. Bush. A great deal has been written about the war on drugs. See, for example, Steven R. Belenko, ed., *Drugs and Drug Policy in America: A Documentary History*, Westport, Connecticut: Greenwood Press, 2000; H. Richard Friman, *NarcoDiplomacy: Exporting the U.S. War on Drugs*, Ithaca, New York: Cornell University Press, 1996; James A. Inciardi, *The War on Drugs: Heroin, Cocaine, Crime, and Public Policy*, Palo Alto, California: Mayfield Publishing Company, 1986; Kenneth J. Meier, *The Politics of Sin: Drugs, Alcohol and Public Policy*, Armonk, New York: M.E. Sharpe, 1994; Musto (1999); William O. Walker III, *Drug Control in the Americas*, revised edition, Albuquerque, New Mexico: University of New Mexico Press, 1989; Steven Wisotsky, *Beyond the War on Drugs: Overcoming a Failed Public Policy*, Buffalo, New York: Prometheus Books, 1990.

79 Musto (1999), page 248-259; Bruun *et al.* (1975), ch. 10.

80 The U.S. campaign included massive international funding for crop substitution, technical assistance to improve the administration and law enforcement, initiatives to combat smuggling, and coordination of educational programs. However, many developing countries were wary of U.S. money with strings attached. The Americans saw the Fund as a way to get around that reluctance. (McAllister (2000), page 236-237)

The emphasis was on law enforcement and crop substitution rather than abuse and demand-oriented strategies. Money went primarily to projects that involved U.S. allies and focused on countries where the U.S. had been unable to stop opium production.[81]

The Fund was also sharply criticized for succumbing to the inefficiency of the UN's bureaucratic machinery: *"A large proportion of the money allocated to the Fund's various programs is in fact spent on supporting an ever-expanding bureaucracy to administer the programs. Indeed many of the Programs appear to serve no purpose other than to provide occupation for the enlarged secretariats."*[82] It was also argued that the UNFDAC should be transferred from the drug control bodies under ECOSOC to the United Nations Development Program, which was better able to assess the development and aid needs of recipient countries.[83]

Another key initiative of the Nixon administration was to strengthen the Single Convention. As a result of heavy U.S. lobbying, a UN plenipotentiary conference was convened in March 1972 to amend the Convention.[84] What came out of the conference was the Single Convention Protocol. The main goal of the amendments was to expand the INCB's role in controlling licit and illicit opium production and illicit drug trafficking in general. The U.S. wanted to revive certain aspects of the 1953 Opium Protocol by attempting to reduce licit opium production. However, in 1972, licit production was just meeting licit demand, and few countries were willing to risk a global shortage of opium for medical use.[85] Consequently, the U.S. proposals were significantly diluted.

The backbone of the Single Convention Protocol consists of provisions that enhance the INCB's powers, especially in relation to illicit trafficking. In Article 2 of the Single Convention, the definition of the INCB's functions now includes an explicit reference to the prevention of *"illicit cultivation, production and manufacture of, and illicit trafficking in and use of, drugs."* Article 35 encourages Parties to supply the INCB and the CND with information on the illicit drug activity in their territory; as well, the INCB is empowered to advise Parties on their efforts to reduce illicit drug trafficking. When Parties conclude extradition treaties with one another, such agreements are now deemed to automatically include the drug-related offences set out in the Single Convention, including trafficking.[86] Article 22(2) of the Psychotrop[illegible] Convention says only that it is "desirable" that such offences be made extraditable.

[81] *Ibid.*, page 238.

[82] Bruun *et al.* (1975), page 281.

[83] *Ibid.*, page 282; Kušević (1975), page 51.

[84] U.S. ambassadors were selected specifically for the purpose of visiting signatory countries to persuade their leaders to support the amendments proposed by the U.S. It is widely believed that the conference was largely an instrument that Nixon planned to use in the approaching presidential election. (Kušević (1975), page 47)

[85] Kušević (1975), page 48. According to Kušević, it would have been better to try to reduce the *diversion* of licit demand into the illicit market.

[86] Single Convention, Article 36, as amended by the Single Convention Protocol, Article 14.

The Protocol amended the Single Convention's abuse prevention provisions to bring them into line with Article 20 of the Psychotropics Convention.[87] The amended Single Convention also echoes the Psychotropics Convention by now allowing countries to use *"treatment, education, after-care, rehabilitation and social reintegration"* either as an alternative to or in addition to conviction or punishment.[88]

Although not as stringent as originally intended by the U.S., the Single Convention Protocol continued the prohibitive tradition of the international drug control regime, especially against opium, and stepped up the war on illicit trafficking.

Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

Numerous national and regional drug control initiatives were launched in the 1970s and 1980s.[89] In Europe, the Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs, also known as the "Pompidou Group," was created to facilitate discussions between countries. In addition, the Heads of National Law Enforcement Agencies (HONLEA) met regionally - in Asia and the Pacific in the 1970s, and in Africa, Latin America and Europe in the 1980s - to improve police and customs drug enforcement cooperation. INTERPOL expanded its operations and became "an important clearinghouse for information and a sponsor of local, regional, and global drug enforcement meetings."[90]

Meanwhile, concerns arose within the UN and among its main control-oriented members that the anti-trafficking efforts of the international drug control system were being compromised by the fact that certain nations were not Parties to the Conventions or did not have domestic law enforcement systems capable of properly combating illicit trafficking.[91] In 1984, the UN General Assembly adopted resolution 39/141, which called on ECOSOC to instruct the CND to prepare "as a matter of priority" a draft convention considering *"the various aspects of the problem [of illicit drug trafficking] as a whole and, in particular, those not envisaged in existing international instruments."* Thus, the goal was to add an additional, trafficking-specific layer to the drug control system to complement the two existing Conventions.

---

87 *Ibid.*, Article 38, as amended by the Single Convention Protocol, Article 15.

88 *Ibid.*, Article 36, as amended by the Single Convention Protocol, Article 14.

89 In the U.S., the war on drugs lost some momentum in the 1970s during the administrations of Presidents Gerald Ford and Jimmy Carter. Eleven U.S. states decriminalized certain aspects of marijuana regulation and were supported by well-known organizations such as the American Medical Association, the American Bar Association, the American Public Health Association and the National Council of Churches. President Ronald Reagan reversed this trend in the early 1980s. (Wisotsky (1990), page xviii)

90 McAllister (2000), page 242-243.

91 Bewley-Taylor (1999), page 167; David P. Stewart, "Internationalizing the War on Drugs: The UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances," *Denver Journal of International Law and Policy*, Vol. 18, No. 3, Spring 1990, page 387-404.

The draft treaty was finalized at the 1987 UN Conference on Drug Abuse and Illicit Trafficking. Also at this Conference, a Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control[92] (CMO) was adopted to encourage states to fulfil their existing treaty obligations. The CMO focused on four areas: (1) prevention and reduction of illicit demand; (2) control of supply; (3) suppression of illicit trafficking; and (4) treatment and rehabilitation. Many of the objectives described in the CMO were reflected in the draft treaty. Between 25 November and 20 December 1988, representatives of 106 states met in Vienna to negotiate a final text. The result was the Trafficking Convention.

The Trafficking Convention is essentially an instrument of international criminal law. Its aim is to harmonize criminal legislation and enforcement activities worldwide with a view to curbing illicit drug trafficking through criminalization and punishment. Under the Convention, Parties are required to enact and implement very specific criminal laws aimed at suppressing illicit trafficking. These laws relate to such aspects of the problem as money laundering, confiscation of assets, extradition, mutual legal assistance, illicit cultivation, and trade in chemicals, materials and equipment used in the manufacture of controlled substances. As with the other two Conventions, the CND and the INCB are charged with administration of the Convention. Furthermore, for minor offences, the Trafficking Convention allows demand-side measures to be used as an alternative to conviction or punishment.[93]

The Preamble describes illicit trafficking as "*an international criminal activity*" and points out the "*links between illicit traffic and other related organized criminal activities which undermine the legitimate economies and threaten the stability, security and sovereignty of States.*" It also stresses "*the importance of strengthening and enhancing effective legal means for international co-operation in criminal matters for suppressing the international criminal activities of illicit traffic.*" Even the single reference in the Preamble to demand-side issues is couched in terms specific to criminal law: "*Desiring to eliminate the root causes of the problem of abuse of narcotic drugs and psychotropic substances, including the* **illicit demand** *for such drugs and substances and the enormous profits derived from illicit traffic*" (emphasis added). The implication is that drug users also are to be considered criminals. The Preamble clearly reflects its prohibitionist roots, even explicitly reaffirming "*the guiding principles of existing treaties in the field of narcotic drugs and psychotropic substances and the system of control which they embody.*"

Accordingly, the cornerstone of the Trafficking Convention is Article 3: "Offences and Sanctions." Here the treaty breaks new ground by *requiring* that Parties "legislate as necessary to establish a modern code of criminal offences relating to the

---

[92] *Declaration of the Conference on Drug Abuse and Illicit Trafficking, and Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control*, UN document ST/NAR/14, 1988.

[93] For a detailed description of the provisions of the Trafficking Convention, see William Gilmore, *Combating International Drugs Trafficking: The 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, London: Commonwealth Secretariat, 1991; Stewart (1990). Since Stewart was a member of the U.S. delegation that took part in the negotiations, his article presents the U.S. perspective on the treaty.

various aspects of illicit trafficking and to ensure that such illicit activities are dealt with as serious offences by each State's judiciary and prosecutorial authorities."[94] The mandatory offences, set out in Article 3(1), include the following:

- The production, manufacture, distribution or sale of any narcotic drug or psychotropic substance in violation of the provisions of the Single Convention or the Psychotropics Convention;
- The cultivation of the opium poppy, coca bush or cannabis plant in violation of the above Conventions;
- The possession or purchase of any narcotic drug or psychotropic substance for the purpose of illicit trafficking;
- The manufacture, transport or distribution of materials, equipment and substances for the purpose of illicit cultivation, production or manufacture of narcotic drugs or psychotropic substances;
- The organization, management or financing of any of the above offences.[95]

Furthermore, Article 3(2) of the Trafficking Convention requires each Party, subject to its constitutional principles and the fundamental principles of its legal system, to establish criminal offences for the possession, purchase or cultivation of drugs for personal consumption.

SOME LEEWAY?

Three points bear making concerning the substance of the current conventions.

The first has to do with the absence of definitions. The terms drugs, narcotics and psychotropics are not defined in any way except as lists of products included in schedules. It follows that any natural or synthetic substance on the list of narcotics is, for the purposes of international law, a narcotic, and that a psychotropic is defined in international law by its inclusion in the list of psychotropics.[96] The only thing that the 1961 Convention tells us about the substances to which it applies is that they can be abused. The 1971 Psychotropics Convention, which, as noted earlier, reversed the roles in that the synthetic drug producing countries wanted narrower criteria, indicates that the substances concerned may cause dependence or central nervous system stimulation or depression and may give rise to such abuse as to *"constitute a public health problem or a social problem that warrants international control."*

The second point, following from the first, relates to the arbitrary nature of the classifications. While cannabis is included, along with heroin and cocaine, in Schedules

---

[94] United Nations, *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Done at Vienna on 20 December 1988*, New York: United Nations, 1976, page 48.

[95] See Stewart (1990), page 392; Gilmore (1991), page 5.

[96] Caballero and Bisiou, *op. cit.*, page 26.

I and IV of the 1961 Convention, which carry the most stringent controls, it is not even mentioned by name in the 1971 Convention, though THC is listed as a Schedule I psychotropic along with mescaline, LSD and so on. The only apparent criterion is medical and scientific use, which explains why barbiturates are in Schedule III of the 1971 Convention and therefore subject to less stringent controls than natural hallucinogens. These classifications are not just arbitrary, but also inconsistent with the substances' pharmacological classifications and their danger to society.

Third, if there was so much concern about public health based on how dangerous "drugs" are, one has to wonder why tobacco and alcohol are not on the list of controlled substances.

We conclude from these observations that the international regime for the control of psychoactive substances, beyond any moral or even racist roots it may initially have had, **is first and foremost a system that reflects the geopolitics of North-South relations in the 20th century**. Indeed, the strictest controls were placed on organic substances - the coca bush, the poppy and the cannabis plant - which are often part of the ancestral traditions of the countries where these plants originate, whereas the North's cultural products, tobacco and alcohol, were ignored and the synthetic substances produced by the North's pharmaceutical industry were subject to regulation rather than prohibition. It is in this context that the demand made by Mexico, on behalf of a group of Latin American countries, during the negotiations leading up to the 1988 Convention, that their use be banned must be understood. It was a demand that restored the balance to a degree, as the countries of the South had been forced to bear the full brunt of the controls and their effects on **their own** people since the inception of drug prohibition. The result may be unfortunate, since it reinforces a prohibitionist regime that history has shown to be a failure, but it may have been the only way, given the mood of the major Western powers, to demonstrate the irrationality of the entire system in the longer term. In any case, it is a short step from there to questioning the legitimacy of instruments that help to maintain the North-South disparity yet fail miserably to reduce drug supply and demand.

Putting aside such questions of substance, we will now examine how much leeway countries have within the current conventions to adopt less prohibitionist policies.

Several states have adjusted their criminal enforcement systems to allow *de facto* possession of small amounts of certain soft drugs, such as cannabis and its derivatives, for personal consumption while remaining within the legal bounds of the Conventions.[97] Although the Conventions do not permit legalization or even decriminalization of possession, those countries have circumvented the limitations by criminalizing possession, as required by the treaties, but not strictly enforcing the

[97] For example, Belgium, Denmark, Germany, the Netherlands, Poland and some Australian states. Switzerland is currently considering a bill to legalize cannabis. The next chapter provides more detail on the Australian, Dutch and Swiss approaches in particular.

legislation, or they have effectively "depenalized" the offences by exempting them from punishment.[98]

According to some observers, such approaches clearly violate the spirit of the Conventions, especially the Trafficking Convention, which seems to use the term "trafficking" very broadly to include demand-side activities within a supply-oriented control regime. Yet there is a legal basis for these "softer" approaches because the treaties do not explicitly forbid them.

The hard-nosed criminal law approach adopted by the international drug control system has drawn criticism from human rights activists. Some maintain that the imprisonment penalties are excessive for soft-drug offences such as possession of a small amount of cannabis for personal consumption.[99] It is argued that imprisonment in such circumstances is disproportionate to the offence and therefore violates the inherent dignity of persons, the right to be free from cruel and degrading punishment, and the right to liberty, as set out in such instruments as the *Universal Declaration of Human Rights*, the *International Covenant on Civil and Political Rights*, and the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.*[100] It has also been argued that drug use is a human right and should be recognized as such in the *Universal Declaration of Human Rights.*[101]

The Trafficking Convention is the only one of the three Conventions that mentions human rights. Article 14(2) of the Trafficking Convention explicitly requires Parties "to respect fundamental human rights" when they take measures to prevent and eradicate the illicit cultivation of plants containing narcotic or psychotropic substances, such as opium, cannabis and coca. The same provision also requires states to take into account traditional licit uses, where there is historical evidence of such use, and protection of the environment.

There are three factors that provide states, including Canada, with some leeway. The first is the fact that the conventions recognize the primacy of national legal systems. Indeed, the international drug agreements have no direct application in

---

98 See Krzysztof Krajewski, "How flexible are the United Nations drug conventions?" *International Journal of Drug Policy*, No. 10, 1999, page 329-338. Krajewski provides an excellent overview of the conventions' legal limits in the area of legalization and prohibition. He concludes that legalization or decriminalization would probably require amendment of Article 3(2) of the Trafficking Convention. See also the discussion on legalization in Dupras (1998), page 24-33; and Alfons Noll, "Drug abuse and penal provisions of the international drug control treaties," *Bulletin on Narcotics*, Vol. XXIX, No. 4, October/December 1977, page 41-57.

99 See, for example, the following pages on the Web site of Human Rights Watch, a human rights non-governmental organization: http://www.hrw.org/campaigns/drugs/ and http://www.hrw.org/worldreport99/special/drugs.html.

100 The full text of these international instruments is available on the Web site of the Office of the UN High Commissioner for Human Rights: http://www.unhchr.ch/html/intlinst.htm.

101 See Erik Van Ree, "Drugs as a Human Right," *International Journal of Drug Policy*, Vol. 10, 1999, page 89-98. Van Ree proposes the addition of a new Article 31 to the *Universal Declaration of Human Rights*: Everyone has the right to use psychotropic substances of one's own choice.

national law. To make them enforceable within its territory, the state must enact a law; in Canada, that law is the *Controlled Drugs and Substances Act.* Specifically, the conventions variously state that the proposed penalties are to be imposed "subject to [the Parties'] constitutional provisions" or *"having due regard to their constitutional, legal and administrative systems."* In Canada, the provisions of the *Canadian Charter of Rights and Freedoms* and the interpretations given to them by the Supreme Court are the framework for interpreting the international conventions on drugs.

The second, slightly more technical point suggests that sanctions for possession apply only to possession for the purposes of trafficking, especially in view of this provision's position between two articles on trafficking and of its earlier wording.[102] Failing to punish people for possession for personal use would not be, strictly speaking, prohibited. That is the legal opinion of an expert asked by Switzerland's Federal Office of Public Health to comment on its draft legislation to legalize cannabis: [Translation] *"The statute's general depenalization of the consumption and small-scale cultivation of cannabis would be compatible with the conventions."*[103] With regard to cannabis trade and supply, the author writes: [Translation] *"Even though regulating cannabis trade with a licensing system does not appear to be out of the question, some practical problems remain, partly because of the control mechanisms required by the 1961 Convention, and partly because the international community interprets the 1988 Convention as an obligation to punish the buying and selling of cannabis."*[104]

The third factor is that the conventions impose moral obligations on states and not legal obligations, much less penalties or sanctions for violating them, and that they also include review or amendment mechanisms.

CONCLUSIONS

As we have seen in Chapters 5, 6 and 7, cannabis is widely used in every part of the world, does not have the harmful effects ascribed to it, and poses little risk to public health. Consequently, it in no way deserves to be included in the convention schedules that list what are supposed to be the most dangerous drugs. Cannabis even has therapeutic uses recognized by Canadian courts. For the above reasons, **we recommend that Canada notify the international community of its intent to seek**

---

[102] See Daniel Dupras (1998) *Canada's International Obligations under the Leading International Conventions on the Control of Narcotic Drugs.* Ottawa: Library of Parliament, available on the Committee's Web site at www.parl.gc.ca/illegal-drugs.asp .

[103] Peith, M., (2001) "Compatibilité de différents modèles de dépénalisation partielle du cannabis avec les conventions internationales sur les stupéfiants" [Compatibility of various models of partial depenalization of cannabis with international narcotics conventions]. Legal opinion requested by the Federal Office of Public Health of the Swiss Confederation, page 14.

[104] *Ibid.*, page 15.

the declassification of cannabis as part of a public health approach that would include stringent monitoring and evaluation.

Conclusions of Chapter 19
➢ The series of international agreements concluded since 1912 have failed to achieve their ostensible aim of reducing the supply of drugs. ➢ The international conventions constitute a two-tier system that regulates the synthetic substances produced by the North and prohibits the organic substances produced by the South, while ignoring the real danger which those substances represent to public health. ➢ When cannabis was included in the international conventions in 1925, there was no knowledge of its effects. ➢ The international classifications of drugs are arbitrary and do not reflect the level of danger those substances represent to health or to society. ➢ Canada should inform the international community of the conclusions of our report and officially request the declassification of cannabis and its derivatives.

CHAPTER 20

PUBLIC POLICIES IN OTHER COUNTRIES

As just seen, the international conventions provide the framework for the criminal policy approaches the signatory states may adopt. We have also seen that interpretations vary as to the nature of the obligations they create, specifically with regard to use, and thus possession, for personal purposes. Some interpretations go so far as to suggest that, with regard to cannabis, certain forms of regulation of production could be possible, without violating the provisions of the conventions, as long as the State took the necessary steps to penalize illegal trafficking.

The vast majority of Canadians have heard about the "war on drugs" which the USA is conducting and about its prohibitionist approach, but many would be surprised to see the major variations between states, indeed between cities, within that country. Even fewer know that Sweden enforces a prohibitionist policy at least as strict as that of the US, but through other means. Many of us have, in one way or another, heard about the "liberal" approach introduced in the Netherlands in 1976. Fewer people know of the Spanish, Italian, Luxembourg or Swiss approaches, which are even more liberal in certain respects. More recently, Canadians learned of the decision by the UK's Minister of the Interior to reclassify cannabis as a Class C drugs, but it is not clear that we know precisely what that means. In view of the preconceptions that many may have in relation to France with regard to wine, many may be surprised to learn that its policy on cannabis appears more "conservative" than that of neighbouring Belgium, for example.

As may be seen, once the overall framework of the puzzle has been established by the international community, ways of putting the pieces together vary widely between states, and at times among the regions of a single state. That is why, in order to learn about the experience and approaches of other countries, the Committee commissioned a number of research reports on the situations in other countries[1] and heard representatives of some of those countries in person.[2]

We of course had to make some choices, limiting ourselves to the western countries of the northern hemisphere. This is a weak point, we agree, but our resources

---

[1] Those reports, prepared by the Parliamentary Research Branch staff, concern Australia, the United States, France, the Netherlands, the United Kingdom, Sweden and Switzerland. Exact references appear in Appendix B.

[2] We heard representatives of the United States, France, the Netherlands and Switzerland.

were limited. In addition, as we wanted to compare public policies with data on use trends and judicial practices, we were forced to choose countries with an information base. In our hearings of representatives of those countries, we were mainly limited by time.

In this chapter, we describe the situations in five European countries – France, the Netherlands, the United Kingdom, Sweden and Switzerland – and in Australia and the United States.

FRANCE[3]

Different forms of logic

The new direction taken by the Law of 1970,[4] currently in effect, which penalizes drug use, is, in some respects, more apparent than real. Internal public policy had begun to change in the late nineteenth century, leading to the adoption of the great law on narcotics in 1916, providing criminal penalties for importing, trafficking, possession and use. That legislation, which was particularly strictly enforced for the time (up to three years in prison for narcotics offences) introduced the offence of "use in society". Its passage had been preceded by an intensive "public health campaign" in which narcotics were [translation] "*accused by their detractors of being the root of most of society's ills, that is to say of comprehensively promoting depopulation, moral decadence and, even worse, violent and criminal acts*".[5]

That law was supplemented by the Law of 1922 and the Executive Order of 1939, which stepped up and reinforced its prescriptions. The Law of 1922 required judges to order out of the country persons convicted of trafficking or facilitating use, while the Executive Order increased prison terms to five years. The Law of 1922 also authorized the police to enter homes without prior legal authorization. In Charras' view, "*these various provisions made the French legislation one of the most draconian in Europe.*"[6]

The "therapeutic injunction", another factor causing tension in the 1970 legislation, is in some instances considered the very core of France's drug legislation. Under that provision, [translation] "*an obligation of care may be imposed on every drug user at three points in the penal process:*

---

[3] In this section, we have drawn on a study report prepared by the Library of Parliament: C. Collin, *National Drug Policy: France*, Ottawa: Library of Parliament, 2001, report prepared for the Senate Special Committee on Illegal Drugs.

[4] Law No. 70-1320 of December 31, 1970, respecting health measures in the fight against substance abuse and repression of the trafficking in and use of poisonous substances.

[5] I. Charras, "L'État et les 'stupéfiants'" : archéologie d'une politique publique répressive", in *Drogue. Du bon usage des politiques publiques*. Les cahiers de la sécurité intérieure, page 13.

[6] I. Charras, *op. cit.*, pages 15-16.

- *upon entry into the judicial process, the prosecution may propose an alternative to trial;*
- *during trial, the trial judge or juvenile court judge may impose medical supervision;*
- *at sentencing, the court may impose a health measure either because the user has previously refused it or, on the contrary, to extend it if it commenced under the previous article.*" [7]

Characterized as a [translation] "*humanist counterweight to a repressive policy*",[8] the therapeutic injunction has often been considered by various French observers as an awkward compromise between police powers on the one hand and medical powers on the other.[9]

However, in characterizing the French system as falling between repressing the user as an "offender" and treating him as a "patient", there is a risk of disregarding another aspect of the French approach to drugs at least until the 1970s: the country's foreign policy and the logic of its tax system.

> [Translation] "*The prohibition against drugs is a recent phenomenon. Unlike China, which, since the eighteenth century, has sought to prohibit the use of opium, European countries did not discuss prohibition until the twentieth century. Furthermore, prohibition did not actually become effective until after the 1950s, and there has been no real desire to provide medical care to users until the past 20 years. Before being prohibited or prescribed, narcotic use was taxed through opium and cannabis tax monopolies.*"[10]

Bisiou identifies five known monopolies in the history of colonial France: India from 1864 to 1954, Indochina from 1864 until 1975, in Laos; Oceania from 1877 to 1922 and two cannabis monopolies operated concurrently with tobacco monopolies, one in Tunisia between 1881 and 1954 and the other in Morocco between 1914 and 1952. Another monopoly, the existence of which has not been confirmed, purportedly existed in Lebanon.[11]

These monopolies offered various advantages from a tax and policy standpoint. For tax purposes, they generated significant cash flows, making it possible to finance colonization; from a policy perspective, they were well accepted by the colonies to the extent they pre-existed French colonization and were already well accepted by local populations. What is interesting is the moral character of the "vicious substances" which justified the system for the taxation of luxury products whose consumption

---

[7] L. Simmat-Durand, "Les obligations de soins en France." in C. Faugeron, ed., *Les drogues en France. Politiques, marchés, usages.* Paris: Georg éditeur, 1999, page 111.

[8] M. Setbon, *L'injonction thérapeutique. Évaluation du dispositif légal de prise en charge sanitaire des usagers de drogues interpellés.* Paris: Observatoire français des drogues et des toxicomanies, 2000, page 11.

[9] See *inter alia* L. Simmat-Durand, *La lutte contre la toxicomanie. De la législation à la réglementation.* Paris: L'Harmattan, 2000; J. Bernat de Celis, *Drogues : Consommation interdite.* Paris: L'Harmattan, 1996; and H. Bergeron, *Soigner la toxicomanie. Les dispositifs de soins entre idéologie et action.* Paris: L'Harmattan, 1996.

[10] Y. Bisiou, "Histoire des politiques criminelles. Le cas des régies françaises des stupéfiants.", in C. Faugeron, ed., *Les drogues en France. Politiques, marchés, usages.* Paris: Georg éditeur, 1999, page 89.

[11] Bisiou, *op. cit.*, page 90.

authorities did not wish to encourage. Although abolished at decolonization and characterized by certain internal contradictions between the economic imperatives of profitability and health objectives, this policy, starting in the 1930s, also came under extensive criticism from the international community, whose orientations, as noted above, were increasingly prohibitionist. The history of state drug monopolies has nevertheless marked French history (as it did Dutch, British and Portuguese history) and was another factor in addition to domestic policy.

Thus it was not one single drug policy that France had in the twentieth century, but three often competing forms of logic on the issue. But it was not until the *Mission interministérielle de lutte à la drogue et à la toxicomanie* [Interministerial Mission on Anti-Drug and Addiction Activities] (MILDT) was reinforced in the mid-1990s that a trend emerged toward a more integrated and coherent overall policy.

An integrated public policy

MILDT was established in the early 1980s during the first seven-year term of French President François Mitterrand. Over the years, however, it either lacked leadership or did not have the resources to achieve its ambitions. It was not until Nicole Maestracci was appointed in 1995, under the socialist government of Prime Minister Jospin, that MILDT began to become more visible and take stronger public action. Its activities were directed in particular by the strong controversies and demonstrations conducted by stakeholders of various types (hospital physicians concerned by AIDS, members of NGOs, drug addicts, specialists and others) who criticized the scientific bases of the main objectives of France's drug policy. At the centre of the debate was a need for a harm reduction approach, focusing on reducing AIDS transmission by intravenous drug users and methadone treatment for drug addicts.[12]

In February 1994, only one small group of 77 addicts had access to methadone treatment, whereas there were 160,000 heroin addicts in France at the time. In 1998, medication substitution treatments were offered in France to a group of up to 70,000 addicts, the vast majority of whom received Subutex and methadone replacements.[13] This new development clearly shows that public authorities now consider harm reduction a fundamental component of France's drug policy.[14]

On June 16, 1999, the French government introduced a three-year plan clearly reflecting this paradigm shift since palliative and preventive measures became legitimate

---

[12] See Ms. Nicole Maestracci, President, Mission interministérielle de lutte à la drogue et à la toxicomanie [Interministerial Mission for the Fight Against Drugs and Drug Addiction], testimony before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, October 1, 2001, Issue no. 7, page 9-10.

[13] Michel Kokoreff, "Politique des drogues en France, entre loi pénale et réduction des risques", presentation to the Senate Special Committee on Illegal Drugs, 2001.

[14] Henri Bergeron, "Comment soigner les toxicomanes?" *Sociétal*, June-July 1998, pages 45-49.

goals in the French policy context. As to criminal policy, the main legislative framework – the law of 1970–has not been amended and drug use is still considered an offence. However, in a circular, the Minister of Justice has asked prosecutors not to seek prison terms and to promote treatment in drug cases.

The plan is based on European and international data and on recent reports, interdepartmental consultations and scientific studies providing fundamental observations on France's policy on drugs and drug abuse. The emergence of new use profiles such as the use of numerous drugs (both legal and illegal), increased cannabis and alcohol use among young people and greater availability of synthetic drugs were the main concerns expressed. Information bases and systems have also come under criticism from various quarters concerning:

- the lack of coordination among prevention programs and their limited accessibility (e.g., school drug prevention programs are offered to less than 40 per cent of students and those concerning alcohol and tobacco to less than 20 per cent);
- the lack of social and professional support;
- the fact that there is no ground for agreement among the various stakeholders (law enforcement, social welfare, education and public health);
- the excessive importance attached to heroin addicts in the administration of specialized treatment at a time when use among the members of this addicted group has stabilized;
- the difficulty in reconciling law enforcement with the public health strategy.[15]

Criminal law enforcement with respect to drug users has been constantly marked by the difficulties inherent in reconciling suppressive activities with public health imperatives. The number of users who have been questioned by authorities has doubled over the last five years, without the judicial system having permitted adequate and effective cooperation with physicians and social workers.[16]

Furthermore, observing the declining number of trafficking arrests at the local level since 1996, elected representatives and the general public find this hard to understand in view of the importance they feel should be attached to monitoring drug

[15] Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT), *Three-Year Plan to Combat Drug Use and Prevent Dependence 1999-2001*. Available online at: http://www.drogues.gouv.fr/uk/what_you_need/whatyouneed_intro.html.

[16] Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT), "An Information Booklet Summarising the Government's Plan for the Fight Against Drugs and the Prevention of Addiction 1999-2000-2001", *Drugs: No More, Risk Less*, MILDT, December 1999, page 7. Available online at: http://www.drogues.gouv.fr/fr/index.html.

supply. Lastly, the shortage of reliable indicators has prevented any in-depth, or even comprehensible, assessment of existing programs.

Based on these observations, the government has developed a three-year plan defining action priorities, objectives and measures that should be taken. Two key factors – integration and knowledge – are the watchwords of this effort. Integration is viewed from two standpoints: for the first time, France will have an integrated policy on all psychoactive substances, drugs, medications, alcohol and tobacco.

> *The fact that we were talking about alcohol, tobacco and medication at the same time as we were talking about drugs no doubt made everyone feel closer to the situation because everyone had the experience of consuming a product, be it legal or illegal. This was an important aspect that did not result in our saying that all of the products should come under the same legislative regime, but [that made it possible, regardless of the product used] to distinguish between occasional use and problem use.* [17]

The other aspect of integration is a reinforced effort among the 19 departments that form the MILDT under the chairmanship of the Prime Minister.

The second watchword of this French effort is knowledge. As noted above, a certain number of observers had noted weaknesses in the knowledge apparatus, including reports commissioned by various authorities (discussed below). In the wake of the impetus given by President François Mitterrand to the creation of the European Monitoring Agency for Drugs and Drug Addictions, France, in 1993, established the French Monitoring Centre for Drugs and Drug Addictions. The mission of the French Centre, which is an "independent" agency, is to "develop the observation network in order to monitor recent trends in drug use, conduct regular epidemiological surveys on the public and implement a comprehensive public policy evaluation framework".[18] To do so, it organizes its work along three main lines: observation and improvement of indicators, monitoring of recent trends and policy evaluation. The Centre has a staff of 25 persons and a budget of 18 million French francs (approximately Cdn $3.5 million). It is also the national focal point in the network of the European Monitoring Centre for Drugs and Drug Addictions.

Legislative framework

French law related to illicit drugs is drawn from many sources including four codes: the Code of Public Health (code de la santé publique), the Penal Code, the Code of Penal Procedure, and the Customs Code. The main legislative framework is the law of 31 December 1970, which amended the Code of Public Health and created a legislative framework based on both the application of repressive measures and health-related dispositions. The objectives of the Law of 1970 were to severely repress

---

[17] Nicole Maestracci, testimony before the Senate Special Committee on Illegal Drugs, page 13.

[18] Observatoire français des drogues et des toxicomanies, *Drogues et dépendances. Indicateurs et tendances 2002.* Paris: author, 2002, page 291.

trafficking, prohibit the use of narcotics, and yet propose alternatives to the repression of use, as well as to ensure free and anonymous care for users seeking treatment. [19] It must be noted that most articles of the Law of 1970 (originally written into the Public Health Code) have since been integrated into the new penal code that came into force in 1994 except for infractions related to drug use, which are still sanctioned through the Public Health Code. French law is also governed by international law since France has ratified the UN conventions related to drugs.

Classes of drugs

French law does not distinguish between illicit substances and thus, an offence such as drug use is prosecuted and judged in the same way regardless of the illicit substance involved. However, judicial authorities may take into consideration the nature of the substance, the quantity and any prior criminal records in their decision to prosecute, reduce the charges or not prosecute an offender. Illicit substances are listed in an annex to Decree Law of 22 February 1990 and include the following:

List I: narcotic substances such as heroin, cocaine, cannabis, methadone, opium, etc.;
List II: substances such as codeine, propiram, etc.;
List III: psychotropic substances such as amphetamines, Ecstasy, LSD, etc.; and
List IV: synthetic drugs such as MBDB, 4-MTA, Ketamine, Nabilone, THC, etc.[20]

Offences and penalties

Public or private drug use in France is prohibited and criminalized by the Law of 1970 (article L3421-1 of the Code of Public Health). The penalty for illicit drug use is up to one year in prison or a fine of 25,000 French Francs, or diversion to a court-ordered treatment program (therapeutic injunction–in French, "*injonction thérapeutique*"). This article of the Code of Public Health applies to all users without any distinction as to the type of illicit substance used.

The Code of Public Health also provides for the monitoring of drugs users by health authorities (article L3411-1). Prosecutors may not undertake legal action against an offender if that person can provide medical certification that he has undertaken some form of therapy or has submitted himself to medical supervision since the commission of the infraction. However, if the offender does not supply a medical certificate to that effect, prosecutors may request that an individual who has made use of illicit drugs follow a drug addiction treatment program or be placed under medical monitoring (article L3423-1). The involvement in a court-ordered treatment program

---

[19] Observatoire français des drogues et des toxicomanies (OFDT), *Drogues et toxicomanies : indicateurs et tendances*, 1999 Edition, page 20. Available online at: http://www.drogues.gouv.fr/fr/index.html.
[20] Observatoire européen des drogues et des toxicomanies (OEDT)/ *European Legal Database on Drugs (ELDD), France Country Profile, French Drug Legislation.* Available online at: http://eldd.emcdda.org/databases/eldd_national_reviews.cfm?country=FR.

suspends legal proceedings and these will not be pursued if the individual completes the detoxification program.[21] It is not uncommon for a repeat offender to be subjected to more than one court-ordered treatment program as more repressive measures are rarely used for simple drug use, particularly cannabis use.

As mentioned above, the Ministry of Justice – in a directive dated June 1999 – asked prosecutors to prioritize treatment over incarceration for small-time offenders and problematic drug users. Practice has shown that therapeutic alternatives are used mainly for simple users and that most cases of simple drug use receive a warning with the request to contact a social or health service. When legal proceedings are undertaken, the magistrate may also force, and not simply order, the accused to undertake a detoxification program but in this case, judicial authorities take charge of the case rather than health authorities. In these cases, if the user completes the treatment, no penalties may be imposed on the individual but the use of such measures are extremely rare. [22] As well, a detoxification treatment may be a condition attached to a conditional prison sentence, parole or judicial supervision. In France, the delinquent user is thus seen mostly as a sick person to whom therapy must be offered. [23]

On the drug trafficking side, the Law of 1970 has been modified on several occasions, creating new offences such as the selling or supplying drugs for personal use (17 January 1986) and drug-related money laundering (31 December 1987), or enacting new procedures such as the confiscation of drug trafficking profits (14 November 1990) to comply with Article 5 of the United Nations Convention (19 December 1988).[24] Currently, trafficking offences include selling or supplying drugs for personal use with a penalty of up to five years and a fine of up to 500,000 F (articles 222-39 of the Penal Code) and a more serious offence for transportation, possession of, supply, sale and illicit purchase of narcotics with a penalty of up to 10 years and a fine up to 50 million F (article 222-37). Illicit imports and exports of narcotics are also punishable by 10 years' imprisonment and a fine up to 50 million F but when the offence is committed by a criminal organization, the penalty increases to 30 years of imprisonment (article 222-36). Furthermore, trafficking in narcotics might also be punishable as a customs offence (contraband and similar offences) with a maximum sentence of three years' imprisonment and fines equalling two-and-one-half times the value of the illegal merchandise. Prosecutions under the Customs Code do

---

[21] Comité consultatif national d'éthique, *Rapports sur les toxicomanies*, rapport no 43, November 23, 1994, page 19. See: http://www.ccne-ethique.org/français/start.htm.

[22] OEDT/ELDD, *France Country Profile*, 2001.

[23] Comité consultatif national d'éthique, 1994.

[24] United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, December 19, 1988: Article 5, Confiscation 1. Each Party shall adopt such measures as may be necessary to enable confiscation of: (a) Proceeds derived from offences established in accordance with article 3, paragraph 1, or property the value of which corresponds to that of such proceeds; (b) Narcotic drugs and psychotropic substances, materials and equipment or other instrumentalities used in or intended for use in any manner in offences established in accordance with article 3, paragraph 1.

not exclude penal prosecution, and customs sanctions can be added to penal sanctions.[25]

Other offences include the illegal production or manufacturing of narcotics punishable by 20 years in prison and a fine of 50 million F. Here again, when a criminal organization commits the offence, the penalty increases to 30 years' imprisonment (article 222-35). Drug-related money laundering defined as "*facilitating by any means, false justification of the source of assets or revenues of the author of an infraction to narcotics legislation*" is punishable by 10 years imprisonment and a fine of 5 million F (article 222-38). Incitement to drug use or to commit any offence sanctioned by articles 222-234 to 222-239 of the Penal Code or to present these offences in a favourable light is punishable by five years in prison and a fine of 500,000 F (article L3421-4 of the Code of Public Health). This offence is aimed at the media and literary or artistic works. Inciting a minor to use narcotics is punishable by five years' imprisonment and a fine of 700,000 F and in the case of a minor under the age of 15 years or if the offence is committed in or around an educational establishment, the penalty increases to 7 years in prison and a fine of 1 million F (article 227-18). Finally, heading or organizing a group engaged in the production, manufacturing, import and export, transportation, possession, supply, sale, purchase or use of narcotics can lead to a life sentence and a fine of 50 million F (article 222-34).

Key reports

The Pelletier Report

The first assessment of the Law of 1970 and of the French policies with respect to drugs and drug addiction was completed in 1978 by a commission presided by Monique Pelletier, who studied the issue at the request of French President Giscard d'Estaing.[26]

The Pelletier report stated that the difficulties encountered in the implementation of the Law of 1970 were the result of inequalities in handling drug users due in part to the fact that the law did not include an intermediate category between a drug user and a trafficker. The report also attributed the implementation problems to the difficulties encountered in getting legal and health authorities to work together.[27] Doctors were particularly sceptical about the principle of court-ordered treatment and of forcing an individual into treatment. The Pelletier Commission noted as well that legal sanctions were used more often than treatment alternatives. Members of the Pelletier Commission believed that the Law of 1970 deserved a second chance. They suggested

---

[25] OEDT/ELDD, *France Country Profile*, 2001.

[26] M. Pelletier, *Rapport de la mission d'étude sur l'ensemble des problèmes de la drogue*, Paris: La Documentation française, 1978.

[27] Centre d'aide et d'accueil en toxicomanie (CAAT), *La mise en application de la loi.* See: http://caat.multimania.com/info/app_loi.htm.

that it could benefit from the institution of clear implementation guidelines (circular letters) and the establishment of structural and financial resources to ensure the successful implementation of therapeutic alternatives, both at the judicial and medical level. The report proposed, among other suggestions, that drug users should be differentiated according to the type of illicit substance they use.[28]

Officially today, the law still does not distinguish between illicit substances but in practice many circular letters over the past 20 years have invited prosecutors and judges to differentiate between cannabis use and use of other drugs such as heroin and cocaine. For example, a circular letter (7 May 1978) suggested that cannabis users should not be considered "true" drug addicts, that detoxification treatment may not be the appropriate measure for this type of user, and that they should receive a simple warning. It also invited judges to encourage drug users to contact a drug addiction centre and to only use court-ordered treatment for repeat offenders. This circular letter has been perceived by many as a decriminalization of cannabis use. However, it must be noted that circular letters express the intentions of the Ministry of Justice but can be enforced diversely by prosecutors.[29]

The 1978 circular letter was a point of reference until 12 May 1987 at which time a Justice-Health circular repealed preceding letters and introduced a new distinction for drug use based on the frequency of use.

> [Translation] *For all cases involving drug use, a report had to be sent to the prosecution and dealt with by a specialized judge. "Occasional" users, who were well integrated into society were to be given a simple warning. The letter recommended court-ordered treatment or prosecution for "habitual" users. Illegal foreign users were to be immediately tried and banned from the French territory. Lastly, user-dealers or delinquent users were to be prosecuted as a head dealer or for harming others or goods. This letter also marked a will to revive court-ordered treatment and clarified how it should be enforced.*[30]

This circular letter was a turning point towards more repressive measures for habitual users and user-dealers[31] and the basis of the orientation of legal policy between 1990 and 1995, which focused on reviving court-ordered treatment and distinguishing between occasional users, habitual users, and user-dealers.[32]

The Trautmann Report

The second report was commissioned in 1989 from Catherine Trautmann who, at the time, was the president of the Interministerial Mission for the Fight against Drugs and Drug Addiction. The Trautmann report, submitted in 1990, included a review of

[28] OFDT, 1999, page 25.
[29] *Ibid.*
[30] *Ibid.*, page 26.
[31] CAAT, 2001, page 3.
[32] OFDT, 1999, pages 26-27.

available data on drug use and drug addiction, the main difficulties in the fight against drugs, and the drug policy in France from 1978 to 1988.[33]

The report did not recommend any changes to the Law of 1970. Rather, it highlighted the need for more effective actions against drug trafficking, with a particular focus on developing better cooperation between the three main national services involved in the fight against drug trafficking: the police, the gendarmerie, and customs – each of which have a different jurisdiction (urban areas for the police, rural areas for the gendarmerie, borders for customs). It suggested that the policing of French outer borders should be reinforced. The report further proposed that more should be done to deal with the demand side of the drug issue by developing strategies aimed at preventing drug use and drug addiction, particularly among young people. Suggestions related to the care of drug addicts and their integration and reintegration into the community revolved around three main axes: improving health and social services; taking into consideration problems associated with AIDS; and establishing a solid financial management system to support specialized units providing services to drug addicts.

Finally, with respect to the issue of decriminalization or legalization of drugs, in particular cannabis, the Trautmann report was clearly against such propositions. The report stated that the issue is one of preventing drug use and caring for drug addicts, and that decriminalization of cannabis would trivialize drug use and promote earlier and more frequent use of hard drugs.[34]

The Henrion Report

The Henrion Commission produced in 1995 a third report on the drug situation in France.[35] It is interesting to note that the Commission comes to similar conclusions as the two previous reports with respect to the lack of coordination and cooperation between judicial and health authorities and the difficulties in implementing a policy based on both repressive and public health measures. The Commission made note of the limited use of court-ordered treatment and the increasing number of arrests for simple drug use. It recommended first and foremost the development of an evaluation policy to assess the drug situation in France and suggested that French drug policy should give priority to preventing drug use. As well, the report criticized the lack of consistency in law enforcement and inequalities in handling drug users throughout France and recommended that the existing agencies and structures involved in the repression of drug trafficking be given the necessary financial and human resources to successfully achieve their mandate.

---

[33] C. Trautmann, *Lutte contre la toxicomanie et le trafic de stupéfiants*. Report to the Prime Minister, Paris: La Documentation française, 1990.

[34] *Ibid.*, Annexe 10, pages 252 and 253.

[35] R. Henrion, *Rapport de la Commission de réflexion sur la drogue et la toxicomanie*. Report to the Minister of Social Affairs, Health and Cities, Paris: La Documentation française, 1995.

However, the Henrion Commission distinguished itself in proposing a reform of the Law of 1970. Members of the Commission debated the issue of decriminalizing cannabis, expressing diverging opinions on the issue. A minority of members (8 out of 17) opposed the idea of decriminalizing the use of cannabis mainly because they thought it would be difficult to maintain a moral interdiction without a legal prohibition. However, a small majority of members (9 out of 17) were in favour of decriminalizing the use of cannabis and possession of small quantities of such substance. They suggested proceeding gradually without effecting any changes to the existing measures sanctioning the supply of cannabis in the hope of better controlling and assessing the consequences of decriminalizing drug use. They also recommended that decriminalization should be accompanied by the enactment of regulations limiting use of cannabis to certain locations and forbidding its use by young people under the age of 16. Regulations would also repress being intoxicated in public places, create an offence of driving under the influence of cannabis, and would prohibit the use of cannabis by certain professionals for safety reasons (i.e., air traffic controllers; pilots, drivers of public transit, etc.). All these measures had to be accompanied by a prevention campaign focusing on the potential negative consequences of using cannabis, an ongoing evaluation not only of cannabis use but of opiates, cocaine and crack as well, and ongoing neurobiological research on the effects of cannabis use. Finally, the offence of incitement to drug use was to be maintained and applied.[36]

The Commission suggested that, if such a reform was applied and there was no deterioration of the situation within two years, the government should then consider a regulation of the commerce of cannabis under the strict control of the state. It should be noted, however, that some members of the Commission thought that such a regulation should be implemented concurrently with the decriminalization of cannabis and that there should not be any trial period.[37] These recommendations have yet to be implemented.

The Henrion Commission also recommended the adoption of a harm reduction policy that would not limit itself to minimizing the health risks related to drug use, but would be grounded in a public health perspective that would rigorously crack down on specific problem behaviours such as discarding needles in a public place.[38]

Expert reports

In Chapters 5, 6 and 7, we have more fully discussed the scientific data from three recent expert reports, the Roques report on the dangerousness of drugs (1995),[39] the Parquet and Reynaud report on addictive practices (1997)[40] and the INSERM expert

[36] *Ibid.*, pages 82-83.
[37] *Ibid.*, page 83.
[38] *Ibid.*, page 89.
[39] B. Roques, *La dangerosité des drogues.* Paris: Odile Jacob, 1995.
[40] Reynaud, M. et al., (1999) *Les pratiques addictives. Usage, usage nocif et dépendance aux substances psychoactives.* Paris : Secrétariat d'État à la Santé et aux Affaires sociales.

report on cannabis (2001).[41] Those three reports, which supplement each other and are largely consistent in their main conclusions, constitute one of the most rigorous international scientific information bases, and certainly the least ideological, that we consulted. As they were not associated with a commission established to study the public policy aspects of the issue, the three commissions were thus likely in a slightly better position to escape the potential contamination of teleological interpretations of research data.

Statistics on use and offences

Use

The following is from a 1999 document entitled *Drugs and Drug Addictions: Indicators and Trends* prepared by the French Monitoring Centre for Drugs and Drug Addictions, which synthesized available data and analyzed drugs and drug addiction in France.[42]

The current trends observed in that report were as follows:

- a strong decrease in overdose-related deaths (554 in 1994, 143 in 1998) and AIDS deaths associated with injection drug use (1,037 in 1994, 267 in 1997);
- an important drop in heroin use since 1996 possibly attributable to an increase in use of substitution treatments;
- normalization of the use of cannabis as its use is becoming more and more commonplace particularly amongst young people;
- cultivating cannabis is a developing phenomenon;
- synthetic drugs have become much more widely available although these drugs still represent a very small percentage of drug consumption;
- cocaine use is increasing; and
- multiple drug use including licit substances such as alcohol, is an emerging phenomenon especially among youth–54% of young people in care in rehabilitation units are users of at least two products.

Surveys conducted in 1995 amongst a representative cross-section of French adults revealed that almost 25% of 18- to 44-year-olds declared having experimented with cannabis and 7.7% stated that they used it on an occasional or regular basis. Surveys conducted amongst conscripts in army selection centres in 1996 also showed that a large percentage (40%) of young men 18-23 years old had experimented with cannabis and 14.5% had used it during the past month.[43] Whereas adolescents are

[41] INSERM, *Cannabis : Quels effets sur le comportement et la santé?* Paris: author, 2001.

[42] Observatoire français des drogues et des toxicomanies, *Drogues et toxicomanies : indicateurs et tendances*, 1999 Edition. Available online at: http://www.drogues.gouv.fr/fr/index.html

[43] OFDT, 1999, pages 62 and 63.

concerned, it is estimated that in the second half of the 1990s more than one-third of all 15- to 19-year-olds had experimented with drugs, mostly cannabis. Surveys also showed an important increase in the frequency of use of cannabis as "the share of young people who had used cannabis at least ten times during the year increased by over one-half from 1993 to 1997."[44] It was further found that boys are more likely than girls to use illicit substances and at much higher risk of repeated use. A 1998 survey indicated that 33% of the boys declared that they had experimented with cannabis, compared to 23% of the girls.[45] The 2002 report of the French Monitoring Centre for Drugs and Drug Addictions also notes an increase in the number of new health and social cases involving cannabis use: approximately 15 per cent of cases involved cannabis use. Those persons were generally younger than those involved in opiate use, more of them were entering the system for the first time and more had been referred by the courts.[46]

During the second half of the 1990s, the number of "problem" opiate users (drug use that may result in treatment in the health and social system and/or contact with law enforcement agencies) was estimated between 142,000 and 176,000.[47]

Offences

The report from the French Monitoring Centre indicates that the number of arrests for drug-related offences increased from 45,206 to 85,507 over the period 1993-1998. The most important increase was in the number of individuals arrested for cannabis use (30,344 in 1993 compared to 72,281 in 1998) whereas the number of arrests for heroin use had actually decreased (14,959 in 1993, 7,469 in 1998, following a peak at 17,356 in 1995). Cannabis, in fact, accounted for 85% of drug-related arrests in France in 1998 compared to 63% in 1993. However, it must be noted that a little less than half of the individuals arrested for using drugs (45%) were retained for questioning and the vast majority of persons (97.2%) held for questioning were freed in 1997.[48]

Studies in France have emphasized that the statistics on arrests of drug users should be used with caution as it is difficult to ascertain how much of noted changes reflect variations in the population of drug users and how much of these changes are linked to modifications of police and gendarmerie services. For example, data on arrests for use between 1993 and 1998 indicated a significant growth of 30% in use-related arrests in 1997 and 9% in 1998.[49] Many factors may explain such an increase including changes in the behaviour of police and gendarmerie services, the reorganization of

---

[44] *Ibid.*, page 83.

[45] *Ibid.*, page 82-84.

[46] OFDT, 2002, page 96.

[47] OFDT, 1999, page 64.

[48] *Ibid.*, page 112 and 113. It should be noted that release refers to many situations and does not imply that prosecution does not go forward. Some may subsequently be convicted upon being summoned to court.

[49] *Ibid.*, page 112.

police departments, and the normalization of cannabis use. One explanation suggests that a circular letter on court-ordered treatment issued in 1995 by the Ministry of Justice has led public prosecutors to instruct the police and gendarmerie to "systematically report users." [50] It may be assumed that such instructions may have led to the notable increase in drug use-related arrests recorded in 1997.

With respect to trafficking, the number of arrests decreased between 1996 and 1998 from 8,412 to 5,541. Slightly more than half of dealers (52%) arrested in 1998 were trafficking cannabis, 24% were involved in dealing heroin, and 17% trafficked cocaine and crack. The main development was observed in the number of arrests of heroin traffickers which decreased from 3,395 in 1993 to 1,356 in 1998. Arrests for trafficking cocaine increased from 383 to 972 during the same period whereas arrest related to cannabis trafficking increased slightly from 2,456 to 2,920. [51]

The total number of convictions for drug use as the main offence went from 7,434 in 1992 to 6,530 in 1997, with a low of 4,670 convictions in 1995. In 1997, 3,368 convictions were for use only. Of these, 14% were sentenced to imprisonment with an average length of 2.4 months, 35% received a deferred sentence (often associated with probation and court-ordered treatment), 33% were fined, 7% were given an alternative sentence, and 6% were sentenced to an educational measure. The number of convictions for use and transporting increased from 761 in 1991 (6.6% of convictions) to 3,478 in 1997 (22.2%). Convictions for use and trafficking also increased from 475 in 1991 to 1,501 in 1997 (4.1% compared to 9.6% of convictions related to drug offences). In 21% of the convictions for use and other drug-related offences, a prison sentence was given out. In 37% of cases involving drug use and trafficking and 21% of drug use and transporting, individuals received a mixed sentence (prison time and deferred sentence). The average length of imprisonment was 16.8 months in 1997. [52]

In 1998, the number of cannabis seizures was 40,115, up from 27,320 seizures in 1996. However, the quantities seized were smaller in 1998 than in 1996 (55,698 kg compared to 66,861 kg).

Costs

In 1995, public funds devoted to implementing the French drug policy was 4.7 billion Francs. Out of the total expenses (specific budget and interdepartmental credits), approximately 1536.56 million Francs were spent on Justice, 1260.54 million F on police services, 469.55 million F on the gendarmerie, and 450.25 million F on customs expenses. The amount spent on enforcement was considerably higher than that spent on health (656.3 million F) and social affairs (28.58 million F).

---

[50] *Ibid.*, page 114.

[51] *Ibid.*, page 164 and 165.

[52] OFDT, 1999, page 121-123.

More recent figures on interministerial credits indicated that for 1998, the expenditures of health and social affairs were set at 47.9 million F , those of Justice at 18.9 million F, the Ministry of the Interior (police) at 18.5 million F and Defence (gendarmerie) at 10.7 million F.

THE NETHERLANDS[53]

Much has been said about the Dutch approach to the drug issue. The following is one example:

> *In Holland, studies conducted in the early 1990s show the negative impact of tolerance of illegal drugs:*
>
> - *the number of "coffe shops" that have derived income from the sale of hashish since decriminalization in 1990 rose from 20 to 400 in Amsterdam in 1991 to more than 2,000 throughout all of Holland;*
> - *from 1984 to 1988, the number of hashish smokers 15 years of age or more doubled in Holland; from 1988 to 1992, the number of smokers 14 to 17 years of age doubled again, and the number of users 12 and 13 years old tripled;*
> - *the rate of violent crimes committed in Holland is the highest in Europe and is still rising.* [54]

> *In the Netherlands (you have to be careful because there are enormous social and cultural differences preventing any general comparison between Canada and that country), the harm-reduction-based drug policy draws a very clear distinction between cannabis and so-called hard drugs. Since the policy was adopted, cannabis has appeared to be less dangerous and its social approval has increased, particularly among young people whose cannabis use has quadrupled. Cannabis use in that country, as in most continental European countries, based on the statistics cited, remains below that of Canada. But that simply means that we must be even more vigilant. The tendency to have a problem situation and the probability that it will occur appear higher in the country.* [55]

Various witnesses cited the article by Larry Collins published in the prestigious *Foreign Affairs.* However, that article is full of errors of fact.

In view of the climate surrounding the drug policy debate, it is difficult to describe the Dutch approach without giving the impression that one is taking a position. First, we should recall a number of observations we made in Chapter 6, to which we will return in the comparative analysis in the next chapter. First of all, international comparison of use trends must be carefully drawn because of the different methodologies used in the surveys. Second, international comparisons tend to show

[53] This section draws largely on the research report prepared for the Committee by the Library of Parliament: B. Dolin, (2001) *National Drug Policy: The Netherlands.* Ottawa: Library of Parliament, prepared for the Senate Special Committee on Illegal Drugs; available online at www.parl.gc.ca/illegaldrugs.asp.

[54] Canadian Police Association, Brief to the Senate Special Committee on Illegal Drugs, May 28, 2001.

[55] Brief of Dr. Colin Mangham, *Consequences of the Liberalization of Cannabis Drug Policy*, September 17, 2001.

that "*the relationship between the figures measuring cannabis use levels and the legislative model in effect in a country is not obvious or systematic.*"[56]

As was the case for France, we begin with a brief overview of drug legislation in the Netherlands, then describe the broad outlines of the current Dutch policy and the tools used to implement it. We then present current legislation in a more detailed manner and the reports on which it is based, then, lastly, provide some figures on drug use and repression.

Dutch pragmatism?

Like the other colonial powers, the Netherlands maintained opium production authorities and trading posts in their colonies, a system that generated significant tax revenues: between 1816 and 1915, net profits from the sale of opium represented approximately 10 per cent of total revenue from the colonies for the Dutch treasury. The country was also the largest producer of cocaine for medical purposes. It was not until the end of World War II and the independence of Indonesia that the Netherlands terminated the opium monopoly.

> *Vested economic interests in the production and trade of drugs may explain the Dutch reluctance to endorse strong international drug control. Clearly, the Netherlands attempted to protect these interests at the conferences and did so successfully, at least temporarily. (…) Incidentally, the Netherlands also objected to the inclusion of marihuana in the convention.*[57]

During the 1920s and 1930s, the country came under criticism from the League of Nations and the United States in particular over its extensive drug trade. The Netherlands was one of the main heroin producers and the principal producer of cocaine. However, the Dutch negotiators at the international conferences on the various conventions, as well as a portion of the Dutch population itself, did not believe in a system based on prohibition and, already at the turn of the century, felt that a system of government control would be more effective.

It was this attitude that led a number of analysts to represent the Dutch approach to drugs as pragmatic.

> *Dutch society is a pragmatic society. It is a nation of traders, going back to the XVIIth century. Traders are more pragmatic than other people. The pragmatism finds its roots in Dutch history, which is characterized by its fight against the sea, the natural enemy of the Netherlands since the Middle Ages. The Netherlands is roughly the size of Vancouver Island, and today one-half of the country is at sea level.*

---

[56] H. Martineau and É. Gomart, *Politiques et expérimentations sur les drogues aux Pays-Bas.* Rapport de synthèse. Paris: OFDT, 2000, page 44.

[57] M. De Kort, "A Short History of Drugs in the Netherlands", in E Leuw and I. Haen Marshall, eds., *Between prohibition and legalization. The Dutch experiment in drug policy*. Amsterdam: Kugler, 1994, page 11.

> *A system of dykes was built to protect the country. Centuries ago, everyone in Dutch society, from the aristocracy to the farmers worked together to prevent seawater from flowing into the country. The pragmatic attitude comes from that. It is impossible to completely eliminate the problem of the water. It is better to control it with canals.* [58]

However, other factors beyond pragmatism are at work. One Dutch government publication suggests that the nature of Dutch society is the reason for its approach:

> *Some knowledge of the characteristics of Dutch society is required to appreciate the Dutch approach to the drug problem. The Netherlands is one of the most densely populated urbanized countries in the world. Its population of 15.5 million inhabitants occupies an area of 41,526 square kilometers. The Netherlands has always been a transit country: Rotterdam is the largest seaport in the world and the country has a highly developed transportation sector. The Dutch firmly believe in individual freedom and expect the state to be reserved in its approach to religious and moral questions. Free and open debate on such questions is one of the characteristics of Dutch society. Considerable value is attached to the well-being of society as a whole, as may be seen from the extensive social security system and universal access to health care and education.* [59]

It follows that, by tradition, the Dutch are not accustomed to using criminal law to address social problems.[60] Furthermore, the Netherlands is a country of consensus, where there is a long tradition of cooperation between local, regional and national authorities, and between the various sectors of the government.

Whatever the reasons, the Dutch experience has received considerable media coverage, surprisingly, much more than the Spanish approach, which, in many respects, is even more liberal. Being called upon to defend it in Europe and in other international forums, the Dutch have often presented it as a position of compromise between that of the "hawks" of the war on drugs and that of the "doves" of legalisation.[61] It is unlikely that the approach is the result of specific cultural factors and that the Dutch experience cannot apply to other countries. On the contrary, it appears to be the rational solution to a problem by politicians, and that cannot be claimed to be an exclusively Dutch characteristic.

---

[58] Tim Boekhout van Solinge, testimony before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, 19 November 2001, Issue 11, page 53-54.

[59] "Drug Policy in the Netherlands", Government of the Netherlands, available online at: http://www.netherlands-embassy.org/c_hltdru.html.

[60] Boekhout van Solinge, "La Politique de drogue aux Pays-Bas: un essai de changement", *Déviance et Société*, Vol. 22, page 69-71.

[61] C.D. Kaplan *et al.*, "Is Dutch Drug Policy an Example to the World?" in Leuw and Marshall, eds., *op. cit.*

Essential expert reports

Unlike most other countries where commissions of inquiry produced reports in the 1970s, the Netherlands is the only country that has implemented the recommendations of its commission.

The Hulsman Commission(1968-1971)

In 1968, the National Federation of Mental Health Organizations[62] established a commission with a broad mandate to "clarify factors associated with the use of drugs" and "to suggest proposals for a rational policy."[63] Chaired by criminal law professor Louk Hulsman, the Commission had a diverse membership including law enforcement officials, alcohol treatment experts, psychiatrists, a drug use researcher and a sociologist.

The commission's final report, presented in 1971, provided an analysis of drug use and the social mechanisms behind drug problems. New approaches were suggested, including:

- The use of cannabis and the possession of small quantities should be taken out of the criminal law immediately. For the time being, production and distribution should remain within criminal law, but as misdemeanours.
- The use and possession of other drugs should temporarily remain in the realm of criminal law, as misdemeanours, but in the long run all should be decriminalized.
- People who have problems with their drug use should have adequate treatment facilities at their disposal.

In recommending the gradual decriminalization of all drugs, the report noted that illicit drugs can be used in a controlled and limited way and that marginalizing drug-using subcultures has significant negative repercussions. Specifically, becoming a member of the "drug scene" may familiarize a cannabis user with other drugs and patterns of use. Although the commission found no evidence of a "stepping stone" sequence of drug use – what in other contexts has been referred to as "gateways" – it accepted the notion that one kind of drug user (e.g., heroin user) will contaminate another kind of drug user (e.g., cannabis user) when the two kinds of drug use are forced into one marginalized subculture.

---

[62] In the Netherlands, public and private agencies have jurisdiction over mental health based on political affiliation and religious denomination. The National Federation of Mental Health Organizations was a coordination agency.

[63] Louk Hulsman, *Ruimte in het drugbeleid*, Boom Meppel, 1971, page 5, mentioned in Peter Cohen, "The case of the two Dutch drug policy commissions: An exercise in harm reduction 1968-1976" (1994, revised in 1996), Article presented to the 5th International Conference on Drug Harm Reduction, March 7-11, 1994, Addiction Research Foundation, Toronto, available online at: www.cedro-uva.org/lib/cohen.case.html.

With respect to the issue of law enforcement, the commission concluded that once started, drug policing would have to be constantly enlarged to keep pace with the never-ending escalation of drug use. It referred to the criminal law option of opposing drug use as inadequate and "extremely dangerous":

> *Time after time it will show that the means will fall short, upon which those who favour punishment will plead for increase of law enforcement, until it will be amplified a hundred fold from the present situation...This will boost polarization between the different parts of our society and can result in increased violence.*[64]

Although it had no immediate impact, the Hulsman report nevertheless influenced the government report of the Baan Commission.

The Baan Commission (1968-1972)[65]

A State Commission was also established in 1968 by the Under Secretary of Health. This commission contained some members of the Hulsman Commission, as well as officials from the Ministry of Justice, the Amsterdam Chief of Police, and additional psychiatrists and sociologists. In 1970, Pieter Baan, the Chief Inspector of Mental Health, assumed the chairmanship of the commission and a final report was presented in 1972.

The report suggested dividing drugs into those with acceptable and those with unacceptable risks. Further research would be needed to create a greater consensus among the experts as to how some individual drugs should be classified, but the report described cannabis products as relatively benign with limited health risks. However, even for those drugs that pose unacceptable risks, the report concluded that use of the criminal law is not an adequate approach. The Commission suggested the long-term goal of complete decriminalization once a good treatment system had been created. In the interim, the justice system should just be used as a tool for manoeuvring heavy users into treatment.

Other notable findings include:

- The special characteristics of youth culture are important determinants of drug use and if so-called deviant behaviour is stigmatized by punitive measures, the probability of intensification of this behaviour is a serious danger. This will initiate a spiral that will make the return of the individual to a socially accepted lifestyle increasingly difficult.
- Much drug use is short-lasting experimentation by young people.
- Cannabis use does not lead to other drug use, but as noted in the Hulsman report, the criminalization of cannabis promotes contact between cannabis users and the users of "harder" drugs.

---

[64] In Peter Cohen, "The case of the two Dutch drug policy commissions", *supra*, page 3.

[65] *Working Party*, Department of Justice, The Hague, 1972.

- Drug users are better served by drug information and prevention efforts than by prosecution.
- The sometimes unusual behaviour of cannabis-consuming youth is more a result of specific subculture norms and ideologies rather than pharmacology.
- Cannabis use when driving or operating machines in factories is not responsible conduct, and the consumption of cannabis should be restricted to times of leisure in order to limit the risks to the individual or society .

The Baan report formed the basis of what was to become the system of tolerance toward cannabis in the Netherlands as part of a concern for public health and the separation of drug markets.

The Engelsman Report (1985)[66]

Taking notice of the limits of a public health policy essentially based on young people (the principal cannabis users) and of the evolution of heroin use, as well as the declining condition of users, the Engelsman report proposed to extend the Baan Commission's tolerance approach to other drugs. It also went further than the Baan report on the need to rely on the experience and word of users in determining policies, proposing in particular to exclude non-users from the circle of experts. In Engelsman's view, drugs and drug use were no longer the only factors involved in explaining the problems of drugs - hard drugs in this case - and that new factors included the perverse effects of repressive action (care and police) on users. Public policy proposals should therefore not be based on the panic reactions of society and should aim to integrate users and "normalize" their drug use. The state should therefore arbitrate between users and non-users with a view to protecting users. The Engelsman report, which was considered too radical in certain circles, remained a dead letter.

"Continuity and Change" Report – 1995[67]

In 1995, the Dutch government published a report entitled *Drugs Policy in the Netherlands: Continuity and Change*. This policy document was sponsored by: the Minister of Justice; the Minister of Health, Welfare and Sport; and the Secretary of State for the Interior. To some extent, this report was the Dutch response to international pressure (from both neighbouring countries and the USA) as well as an opportunity to make its cannabis policy clearer and to some extent stricter.

The report begins by noting that the Netherlands has always attempted a pragmatic approach to drug use, recalling that prohibitionist policies throughout the

[66] Interdepartmental Task Force on Drugs and Alcohol, The Hague: Department of Justice, 1985.

[67] Department of Foreign Affairs (1995), *Continuity and Change*. 1995. The report is available online at: www.drugtext.org/reports/wvc/drugnota/0/drugall.htm.

world have proven to have a limited effect. Thus, the modest objective in Holland is to limit the health and social problems that result from the use of dangerous drugs. This harm reduction approach has led the Dutch government to distinguish between "hard drugs," i.e., those that pose an unacceptable risk to health, and "soft drugs" such as cannabis products, which although still considered "risky" do not present similar concerns. The underlying assumption made in the Netherlands with respect to cannabis is that people are more likely to make a transition from soft to hard drugs as a result of social factors, not physiological ones. Separating the markets by allowing people to purchase soft drugs in a setting where they are not exposed to the criminal subculture surrounding hard drugs is intended to create a social barrier that prevents people experimenting with more dangerous drugs.

The report goes on to review the effects of the Dutch drug policy, the treatment of addiction in the Netherlands, and enforcement under the *Opium Act*. Key conclusions and findings include:

- Decriminalization of the possession of soft drugs for personal use and the toleration of sales in controlled circumstances has not resulted in a worryingly high level of consumption among young people. The extent and nature of the use of soft drugs does not differ from the pattern in other Western countries. As for hard drugs, the report states that the number of addicts in the Netherlands is low compared with the rest of Europe and considerably lower than that in France, the United Kingdom, Italy, Spain and Switzerland.
- The number of heroin users under the age of 21 has continued to fall in the Netherlands.
- The use of cheaper forms of cocaine (i.e., crack) has not made significant inroads in Holland as had been feared as a result of developments in the United States.
- The tone of public debate in Holland is different than in other countries because drug use is no longer seen as an acute health threat but rather as a source of nuisance. Policies focusing on addiction and care have resulted in less HIV infection; in fact, levels continue to fall. As well, the mortality rate among addicts is low and is not increasing, as it is in other European countries.
- With respect to the legalization debate, the report concludes that, with a state monopoly or licensing system, the disadvantages would outweigh the practical advantages. Although the role of criminal organizations would be reduced, such a system would impose a considerable burden in implementation and monitoring, and would probably attract even more "drug tourists" and the nuisance they sometimes cause. Furthermore, the report suggests that this is not something that could be done by the Netherlands in isolation. The international conventions preclude outright

legalization and would have to be renegotiated or denounced. As well, even if just soft drugs were legal in Holland but not in the rest of Europe, the Dutch criminal organizations that export drugs would continue to exist and would still require significant law enforcement activity.

- Foreign concerns about the Dutch coffee shop policy have centred not on the use of cannabis in the establishments, but on drug tourists who take cannabis back to their home countries, something that has been particularly easy since the abolition of border controls under the Schengen Agreement. The report confirms the government's plan to reduce the purchase limit to 5 grams from 30 grams to see what impact this will have on illegal exports.[68]
- Given the lack of sufficient scientific data, the report endorses the 1995 recommendation of the Dutch Health Council that a medical trial into the effectiveness of prescribing heroin to addicts be undertaken.[69]

The report also notes three negative implications that need to be addressed: the nuisance caused by hard and soft drug users; the increasing presence of organized crime in the Netherlands; and the effect of Dutch policy on other countries.

- The criminal and general nuisance caused by Dutch and foreign hard drug users may have the effect of undermining public support for the policy of social integration of addicts. A small proportion of hard drug users commit a large number of property offences in order to buy their drugs. Contrary to expectations, the fact that methadone is easily obtained has scarcely improved the situation. Drug-related crime and anti-social behaviour, such as discarding used needles in public places, has affected the tolerance levels of residents in some socially disadvantaged neighbourhoods in the larger Dutch cities. Nuisance caused by the presence of coffee shops selling soft drugs has also been problematic in some municipalities.[70]
- Another complication has been the rise of criminal organizations involved in the supply and sale of drugs in Holland which has necessitated increased criminal law measures. The prosecution of drug traffickers will continue to be a top priority for the Dutch police and judicial authorities.
- Although the "ideological nature" of some foreign criticism suggests a lack of understanding of Dutch policy and is often based on purported health risks that are not supported in the scientific literature, there are problems in the Netherlands that have international implications. The Dutch, for example, are responsible for more than their proportional share of

[68] As noted in the section on current legislation, this reduced limit is now in effect.

[69] As noted in the section on current legislation, trials began in 1998.

[70] This concern was addressed subsequent to the Report by the "Damocles bill" of 1999, discussed herein, which provides greater powers to municipalities to shut down coffee shops that are a local nuisance.

trafficking in soft drugs, and drug tourists routinely purchase soft drugs in Holland with the intent of transporting them back to their home country. The report suggests that combating these problems will involve continuing and reinforcing current law enforcement activities that prioritize trafficking. As noted, the issue of soft drug tourists taking home their coffee shop purchases is to be addressed by decreasing the amount permitted for sale.

Three major principles have characterized the Dutch approach since 1976:

- Harm reduction: attenuation of risks and dangers related to drug use rather than prohibition of all drugs, the key elements of which are:
  - prevention or alleviation of social and individual risks caused by drug use;
  - a rational relationship between those risks and policy measures;
  - a differentiation of policy measures based on the risks associated with drugs;
  - repressive measures against drug trafficking are a priority; and
  - the inadequacy of criminal law with respect to other aspects apart from drug trafficking.[71]
- Policy of normalization: social control is achieved through depolarization and the integration of deviant behaviour rather than isolation and removal, as is typical of the deterrence model. This paradigm also suggests that drug problems should be seen as normal social problems rather than unusual concerns requiring extraordinary treatment.
- Market separation: by classifying drugs according to the risks posed and then pursuing policies that serve to isolate each market, it is felt that users of soft drugs are less likely to come into contact with users of hard drugs. Thus, the theory goes, users of soft drugs are less likely to try hard drugs.

Legislation

In 1919, the Netherlands passed its first law on opium under the influence of the international conventions, including the Hague Convention in 1912. That legislation prohibited the manufacture, sale, processing, transportation, supply, import, export and possession of cocaine, opium and its derivatives. The law was amended in 1928 to include cocaine derivatives and cannabis in the list of controlled substances. However, only the import, expert and transfer of those substances were prohibited. The offences

---

[71] M. Grapendaal, E. Leuw and H. Nelen, *A World of Opportunities: Life-Style and Economic Behaviour of Heroin Addicts in Amsterdam.* New York, S.U.N.Y. Press, 1995, mentioned in T. Boekhout van Solinge, "Dutch Drug Policy in a European Context", *Journal of Drug Issues* Vol. 29, No 3, 1999, page 511. Available online at: www.cedro-uva.org/lib/boekhout.dutch.html.

of possession and producing cannabis and cannabis derivatives were not punishable until 1953.

The *Opium Act*–also referred to as the *Narcotics Act*–is the Netherlands' main drug legislation. The *Act* criminalizes possession, cultivation, trafficking and importing or exporting. The 1976 Amendments establishes two classes of drugs: Schedule I drugs are deemed to present an unacceptable risk to Dutch society and include heroin, cocaine, amphetamines and LSD; Schedule II drugs include "traditional hemp products" such as marijuana and hashish.

Offences

The *Act* has three characteristic features:

- it criminalizes possession, trafficking, cultivation, transportation, manufacturing, import and export of drugs, **including cannabis and cannabis derivatives**;
- it draws a clear distinction between suppliers and users; the act punishes possession for the purpose of use, not use as such;
- differentiated penalties based on the substances involved.

The possession of all scheduled drugs is an offence, but possession of a small quantity of "soft" drugs for personal use is a minor offence. Generally, it is tolerated by law enforcement, particularly within the regulated coffee shop system, discussed in the following section. Importing and exporting are the most serious offences under the *Act*.

Penalties

The maximum penalty for importing or exporting hard drugs is 12 years' imprisonment and a fine of 100,000 Dutch florins.[72] Anyone found in possession of a quantity of hard drugs for personal use is liable to a penalty of one year's imprisonment and a fine of 10,000 florins. The maximum penalty for importing or exporting soft drugs is four years' imprisonment and a fine of 100,000 florins. Repeat offenders are liable to a maximum penalty of 16 years' imprisonment and a fine of 100,000 florins. Offenders may also be deprived of any money or property gained from their offence. The Netherlands also has guidelines for sanctions that the Public Prosecutor is directed to seek, based on: the type of drug involved, the amount of the drug and the specific offence. The following tables set out the current guidelines (1996).[73]

---

[72] 100,000 Dutch florins = approximately C$63,000.

[73] Source: Staatscourant (1996) in D.J. Korf and H. Riper, "Windmills in Their Minds? Drug Policy and Drug Research in the Netherlands", *Journal of Drug Issues* , Vol. 29, No. 3, 1999, page 451, Table 2.

SCHEDULE I SUBSTANCES ("HARD DRUGS")		
Offence	Amount	Sanction to be Sought[74]
Possession	< 0.5 g or < 1 user unit	Police Dismissal
	0.5-5 g or 1-10 user units	1 week - 2 months
Possession with Dealer Indication (i.e., intent to sell)	< 15 g or < 30 user units	Up to 6 months
	15-300 g or 30-600 user units	6-18 months
	> 300 g or > 600 user units	18 months - 4 years
Street or Home Dealing	< 1 g	Up to 6 months
	1-3 g	6-18 months
	> 3 g	18 months - 4 years
Middle-level Dealing	< 1 kg	1-2 years
	> 1 kg	2+ years
Wholesale Trade	> 5 kg	6-8 years
Import and Export	< 1 kg	Up to 3 years
	> 1 kg	3-12 years

SCHEDULE II ("SOFT DRUGS")		
Offence	Amount	Sanction to be Sought(75)
Possession, Preparing, Processing, Sale, Delivery, Supply, Transporting or Manufacturing	Up to 5 g	Police Dismissal
	5-30 g	Fine of Dfl. 50-150
	30 g-1 kg	Fine of Dfl. 5-10 per g
	1-5 kg[76]	Fine of Dfl. 5,000-10,000 and 2 weeks per kg
	5-25 kg	Max. fine of Dfl. 25,000 and 3-6 months
	25-100 kg	Max. fine of Dfl. 25,000 and 6-12 months
	> 100 kg	Max. fine of Dfl. 25,000 and 1-2 years

---

[74] In addition to imprisonment, penalties sometimes include fines and property seizures (except for possession).

[75] For repeat offences within five years, the required penalty is increased by one-quarter. As to sales to "vulnerable groups" (that is to say to minors, psychiatric patients), a minimum fine of approximately Cdn $475 is also levied.

[76] Quantities greater than 1 kg are considered as suggesting drug trafficking.

SCHEDULE II ("SOFT DRUGS")		
Offence	Amount	Sanction to be Sought (75)
Cultivation	Up to 5 plants	Police Dismissal
	5-10 plants	Dfl. 50 par plant (repeat offenders: Dfl. 75 per plant)
	10-100 plants	Dfl. 25 per plant and/or ½ day per plant
	100-1 000 plants	Max. fine of Dfl. 25,000 and 2-6 months
	>1 000 plants	Max. fine of Dfl. 25,000 and 6 months – 2 years
Import and Export	The *Act* does not distinguish between quantities, but in practice the prosecutor's sentence recommendation will correspond to the quantity divisions for possession.	Sanctions for possession may be doubled to a maximum of 4 years and a maximum fine of Dfl. 100,000

The coffee shop system

Contrary to several stereotypes, cannabis possession is not decriminalized; strictly speaking, it is still a criminal offence. However, based on the principle of expediency, which is part of the criminal law tradition in the Netherlands, the possession of small amounts of cannabis for personal use has been decriminalized. The sale of cannabis is technically an offence under the *Opium Act*, but prosecutorial guidelines provide that proceedings will only be instituted in certain situations.

Without legalizing the sale of cannabis and cannabis derivatives, the municipalities may permit the establishment of coffee shops which are authorized to sell cannabis under certain conditions. An operator or owner of a coffee shop (which is not permitted to sell alcohol) will avoid prosecution if he or she meets the following criteria:

- no more than 5 grams per person may be sold in any one transaction;
- no hard drugs may be sold;
- drugs may not be advertised;
- the coffee shop must not cause any nuisance;
- no drugs may be sold to minor (under 18), nor may minors enter the premises;
- the municipality has not ordered the establishment closed.

> *The idea behind the Netherlands' policy towards the* coffee shops *is that of harm limitation. This is based on the argument that if we do not prosecute small-scale cannabis dealing and use under certain conditions, the users – who are mainly young people experimenting with the drug – are not criminalized (they do not get a criminal record) and they are not forced to move in criminal circles, where the risk that they will be pressed to try more dangerous drugs such as heroin is much greater.*[77]

It is common for municipalities to have a coffee shop policy to prevent or combat the public nuisance sometimes associated with these establishments. For example, suspicion of selling hard drugs or locating a coffee shop near a school or in a residential district may result in closure. In April 1999, the "Damocles Bill" amended the *Narcotics Act* by expanding municipal powers regarding coffee shops and permitting local mayors to close such places if they contravened local coffee shop rules, even if no nuisance was being caused. As a result of strict enforcement and various administrative and judicial measures, the number of coffee shops decreased from nearly 1,200 in 1995 to 846 in November 1999.[78]

There appears to be three types of policies on coffee shops:

- tolerance without condition as to the number of coffee shops, which is determined by market mechanisms; this situation is the most rare;
- conditional tolerance, setting a maximum number of coffee shops;
- zero tolerance: no coffee shop; this is the case in approximately 50 per cent of Dutch cities.

To determine the ideal number of coffee shops, the association of municipalities recommends that demographic factors (number of inhabitants, age groups) and urban development factors (role of the city with respect to the region; number of centres in the city) be considered, as well as any nuisance caused by the use of soft drugs.

> *Thus, in most municipalities, coffee shops are accepted on in the downtown area, and a maximum number is determined in accordance with criteria of distance – distance of the establishments from one another and distance between the coffee shops and certain institutions such as schools and psychiatric hospitals. (...) The difficulties encountered by certain mayors with regard to administrative judges have come from the fact that the absence of any complaints or contraventions has been considered by certain judges as an absence of any concrete evidence of nuisance. A "substantiated" policy is ultimately a policy based on a procedure for consulting drug addiction and public health experts, police experts and, in certain instances, the public itself (including users). This is also a balanced policy in the sense that it accommodates the interests not only of "average" citizens irritated by public nuisances, but also those of soft drug users.*[79]

---

[77] Dr. Robert Keizer, *The Netherlands' Drug Policy*. Brief to the Senate Special Committee on Illegal Drugs, November 19, 2001.

[78] National Drug Monitor, "Fact Sheet: Cannabis Policy, Update 2000", Trimbos Institute, 2000.

[79] Martineau and Gomart, *op.cit.*, page 85, for the quotation and preceding information.

Since the memo on public nuisances was issued in 1993 and stricter conditions were set for the issuing of permits in 1999, municipal authorities have in fact been able to issue "nuisance permits", which are thus used to monitor the number of coffee shops, without moreover violating the fundamental orientations of the Dutch system.

Data on use

Despite the Dutch "pragmatism", there are ultimately few reliable historical data on use trends. It therefore cannot be asserted that use trends significantly increased after the coffee shop system was introduced, nor can it be stated that they declined. The creation of the Trimbos Institute and its designation as a focal point in the OEDT's European network are correcting this situation.

The following tables contain data from the most reliable surveys.

CANNABIS USE IN THE NETHERLANDS BY PEOPLE AGED 12 YEARS AND ABOVE. SURVEY YEAR 1997

Has ever used	16%
Has used recently	2.5%
Has used for the first time in the past year	1%
Mean age of current users	28 years

CANNABIS USE IN THE FOUR LARGE CITIES AND IN SMALLER TOWNS AMONG PEOPLE AGED 12 YEARS AND ABOVE. SURVEY YEAR 1997

	Ever use	Recent use
Amsterdam	37%	8%
Utrecht	27%	4%
The Hague	20%	4%
Rotterdam	19%	3%
Smaller towns[a]	11%	

(a) Definition: Towns with less than 500 addresses per square kilometre.

CANNABIS USE BY PEOPLE AGED 16 AND ABOVE IN THREE URBAN AREAS. SURVEY YEAR 1999

	Ever use[a]	Recent use[b]
Utrecht	30%	7%
Rotterdam	19%	6%
Parkstad Limburg[c]	13%	5%

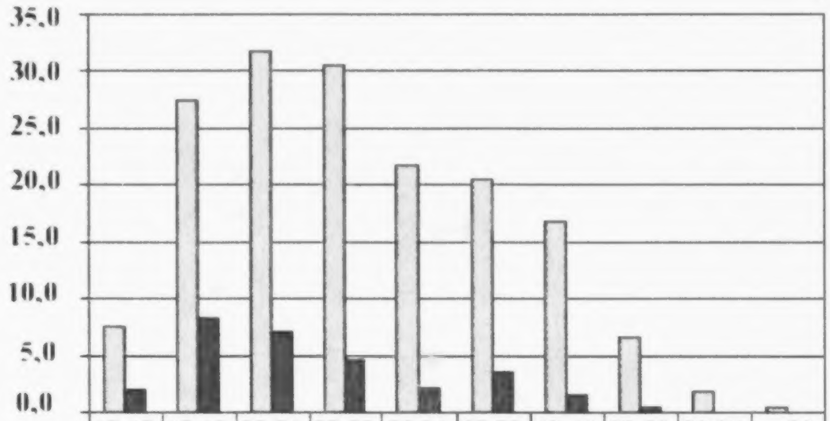
Percentage of users: [a] 16 to 70 years, [b] 16 to 55 years. Recent use: last month.

LEVEL OF CANNABIS CONSUMPTION IN THE NETHERLANDS BY RECENT USERS AGED 12 YEARS AND ABOVE. SURVEY YEAR 1997

Days of use in the last month	*Percentage among recent users*[4]
1-4	45%
5-8	14%
9-20	15%
More than 20 days	26%

(4) Adds up to 100%.

CANNABIS USERS IN THE NETHERLANDS PER AGE GROUP. SURVEY YEAR 1997[80]



	12-15	16-19	20-24	25-29	30-34	35-39	40-49	50-59	60-69	>=70
□ deja utilise	7.5	27.5	31.7	30.6	21.7	20.5	16.8	6.7	1.9	0.5
■ usage recent	2.0	8.3	7.1	4.7	2.1	3.6	1.5	0.5	0.0	0.0

80 We have reproduced this table in its original format, thus we do not have the capacity to change text to English ; "déjà utilisé" means ever used, and "usage récent" means recent use.

WHERE DO YOUNG PEOPLE PROCURE THEIR CANNABIS?

	1996	1999
Obtain cannabis from friends	41%	47%
Purchase cannabis in coffee shops	41%	32%
Purchase cannabis from a dealer	11%	11%
Receive cannabis from others	5%	8%
Purchase cannabis at school	3%	1%
Grow it themselves [a]	-	2%

Pupils aged twelve and above in secondary schools (recent users)
[a] Only measured in 1999.

RECENT CANNABIS USE IN SPECIAL GROUPS

Young persons in	*Survey Year*	*Age*	*Recent Use*
Special schools for secondary education	1997	12-18	14%
Truancy projects	1997	12-18	35%
Judicial institutions	1995	-	53%
Youth care institutions	1996	10-19	55%
Young drifters	1999	15-22	76%

As seen in Chapter 6, the available data on the Netherlands place the country somewhere in the middle of the field, behind Australia, the United States, the United Kingdom, Spain and Denmark, and far ahead of Sweden and Finland.

Whatever the case may be, and despite what some analysts refer to as a disastrous situation, the Dutch experience poses fewer problems in relation to drug use in the Dutch population than internal difficulties in connection with the nuisances caused by the coffee shops for Dutch citizens and neighbouring countries, Germany, France and Belgium, as a result of narco-tourism. Even more significant, the Dutch system, with its half measures, is faced with the problem of supplying coffee shops with cannabis and cannabis derivatives, which is still entirely illegal.

> *Holland does not escape criticism any more than other countries. From a theoretical standpoint, the very principle of de facto legalization is debatable. It fosters arbitrary action and, in particular, leaves the field open to trafficking. As much as the legalization of drug use has made it possible to get a handle on the phenomenon and make it visible so that it can be more effectively addressed, the legalization of trafficking prevents any control. (…) In practical terms, the criticisms are equally fundamental. The main criticism is that the Dutch policy has not reduced the use of drugs, hard or soft. (…) Nor has the Dutch policy eliminated the risks associated with drug abuse. (...) But it must also be recognized, and it is to the credit*

of the Dutch policy that, while the Netherlands has not actually done better than the prohibitionist countries in the fight against drug use, it has not done worse.[81]

Ultimately, the most remarkable thing is the ability of the Dutch stakeholders themselves, as may be seen from their testimony before our committee, to admit the weaknesses and errors of their approach, while constantly seeking ways to correct them.

81 Caballero and Bisiou (2000), *op. cit.*, page 770-772.

UNITED KINGDOM[82]

Ten-year strategy to battle drugs

In 1998, at the same time as the newly elected Labour government announced an imposing crime reduction program, it adopted a 10-year strategy, based on a similar model, to combat drug abuse in the UK.[83] The strategy has four objectives:

- To help young people resist drug misuse in order to allow them to achieve their full potential. The key objective is to reduce the number of people under age 25 reporting use of illegal drugs in the past month and previous year. The program relies on education in schools and prevention efforts focusing on young people at risk.
- To reduce levels of repeat offending among drug-misusing offenders, by giving them the opportunity to take appropriate treatment. To do this, various treatment options were added to the stages of arrest, probation and court appearance. In addition, new drug treatment and testing orders will be made available in all courts in England and Wales. This scheme allows a court, with the offender's consent, to make an order requiring the offender to undergo treatment either in parallel with another community order, or as a sentence in its own right. In addition, the program known as *Carats* (*Counselling, Assessment, Referral, Advice and Throughcare*) is available in all England and Wales prisons, and additional prison-based rehabilitation programs are planned.
- Acknowledging that waiting times are one of the main problems for people requiring treatment and that the supply of treatment services is well below demand, the government plan provides for the creation of a National Treatment Agency which will be responsible for the provision of drug treatment and the delivery of high-quality services. Harm reduction strategies will also be increased.
- To reduce access to drugs among five-to-16-year old children, increase the seizure of Class A drugs and increase assets seized from traffickers.

Ambitious targets relating to the drug strategy have been set out in the Anti-Drugs Co-ordinator's First Annual Report and National Plan, including:

- halving the numbers of young people using illegal drugs (especially heroin and cocaine);

---

[82] This section draws largely on the research report prepared for the Committee by the Library of Parliament: G. Lafrenière, (2001) *National Drug Policy: United Kingdom.* Ottawa: Library of Parliament, prepared for the Senate Special Committee on Illegal Drugs; available online at www.parl.gc.ca/illegaldrugs.asp.

[83] *Tackling Drugs to Build a Better Britain.*

- halving the levels of re-offending by drug-misusing offenders;
- doubling the numbers of drug misusers in treatment; and
- halving the availability of drugs on the streets (especially heroin and cocaine).

Although the 10-year strategy is supposed to focus on the most harmful drugs (heroin and cocaine), the number of people fined, cautioned and in some cases jailed for possession of cannabis still exceeds 100,000 a year.[84]

Legislative framework

The main illicit drug legislation in the UK is the Misuse of Drugs Act 1971 (MDA) (which is equivalent to Canada's *Controlled Drugs and Substances Act*). This legislation and its regulations (Misuse of Drugs Regulations 1985) control the use of listed drugs (including both medical drugs and drugs with no medicinal use). They set out the circumstances in which it is lawful to import, produce, supply, possess with intent to supply, and possess controlled drugs.

Under Schedule 2 of this Act, drugs are classified as either A, B or C in theory to reflect the degree of harm they are considered to cause to the individual or society when misused. Each class has different maximum penalties that apply to prohibited activities in relation to drugs.

- *Class A* is reserved for the more harmful drugs to which more severe penalties apply. This class includes, among others, heroin, morphine, methadone, cocaine, opium and hallucinogens such as Ecstasy and LSD. Also included are liquid cannabis (hashish oil), cannabinol and cannabinol derivatives and any class B drug prepared for injection.
- *Class B* includes cannabis, cannabis resin, less potent opioids (codeine), strong synthetic stimulants (oral amphetamines) and sedatives (barbiturates).
- *Class C* is reserved for drugs that are considered the least harmful such as tranquillzers, some less potent stimulants and mild opioid analgesics.

The Home Secretary can change the classification of drugs through delegated legislation as was just recently done for cannabis. This modification means that possession of cannabis for personal use will not be an arrestable offence but obtain a police caution.

Sections 3 to 6 set out which activities in relation to drugs are prohibited. They include importation and exportation (the actual offences are contained in and prosecuted under the Customs and Excise Management Act 1979), production, supply,

[84] "Drug Laws: the debate nobody wants", *The Guardian*, May 14, 2001.

possession, and possession with intent to supply. Cultivation of cannabis is a separate offence but is also considered production. Under section 8, it is prohibited for the occupier knowingly to permit premises to be used for: production; the supply of any controlled drug; the preparation of opium for smoking; or the smoking of cannabis, cannabis resin or prepared opium. Section 9 provides a series of offences related to opium, including smoking or otherwise using opium. Section 9A prohibits the supply of any article which may be used in the unlawful administration of drugs (hypodermic syringes are excluded from this prohibition for the purpose of needle exchange programs). Sections 18 to 21 create other offences mainly dealing with incitement to commit an offence under the *MDA*.

Penalties are set out in sections 25 and 26. Section 27 deals with forfeiture.

- For class A drugs, the maximum penalties are as follows: seven years and/or unlimited fine for possession; life and/or unlimited fine for production or trafficking with a mandatory seven-year sentence for a third conviction for trafficking. The mandatory sentence for a third conviction of trafficking is found in the Criminal Sentences Act 1997.
- For class B drugs, the maximum penalties are: five years and/or unlimited fine for possession; and fourteen years and/or unlimited fine for production or trafficking.
- For class C drugs, the maximum penalties are: two years and/or unlimited fine for possession; and five years and/or unlimited fine for trafficking.

In addition, producers and traffickers are also liable to confiscation of assets under the Drug Trafficking Act 1994. As stated above, growers of cannabis may be prosecuted under section 4 (production) of the MDA rather than under section 6 (cultivation) of this Act. This is significant because production (but not cultivation of cannabis) is designated a trafficking offence for the purposes of the Drug Trafficking Act 1994. In 1997, a total of 4,168 people were dealt with for production offences of which 92% involved production of cannabis (25% of these offenders were cautioned and 18% of those who were found guilty were sentenced to immediate custody). Offences that are designated as trafficking offences for the purposes of the Drug Trafficking Act 1994 include production, supply, and possession with intent to supply as well as importation offences under the Customs and Excise Management Act 1979. In the UK, most drug offences may be tried summarily by magistrates or on indictment with a jury at a Crown Court. If tried summarily, the maximum cannot exceed six months and/or £5000 fine or three months and/or fine for less serious offences.

Section 7 allows for regulations to be made to exempt certain activities from the offence provisions. This allows for the use of drugs for medicine and for scientific research. The Misuse of Drugs Regulations 1985 divide drugs into five schedules. The regulations set out the classes of persons who are authorized to handle controlled drugs while acting in their professional capacities and lay down the conditions under which certain activities may be carried out. More severe rules regarding importing, exporting,

production, supply, possession, prescribing and record-keeping apply to Schedule 1 drugs with a gradual loosening of the rules for other schedules. For example, the most restricted Schedule 1 drugs (such as LSD and cannabis) can be supplied or possessed only for research or other special purpose by licensed individuals and are not available for normal medical uses and cannot be prescribed by doctors who do not have a licence. Schedule 2 drugs–which must be prescribed–are subject to a number of controls relating to prescriptions, secure storage and the need to keep records. Schedule 5 drugs, meanwhile, are subject to the least administrative controls and may be freely imported, exported or possessed for personal use.

Cannabis and certain psychoactive cannabinoids and derivatives are classified under Schedule 1 as having no therapeutic benefit. Thus, they cannot be prescribed and can only be possessed for research purposes by someone who is licensed to do so. Nabilone (a synthetic cannabinoid) is licensed for prescription to patients with nausea or vomiting resulting from cancer chemotherapy, which has proved unresponsive to other drugs. Dronabinol (a cannabinoid) has been rescheduled from Schedule 1 to Schedule 2 and can be prescribed. However, it remains unlicensed in the UK and has to be prescribed on a "named patient basis."

Section 10 allows the making of regulations dealing with safe custody, documentation of transactions, record-keeping, packaging and labelling, transport, methods of destruction, prescriptions, the supply of information on prescriptions to a central authority, the licensing of doctors to supply controlled drugs to addicted patients, and the notification by doctors of their addicted patients.

The Misuse of Drugs (Supply to Addicts) Regulations 1997 restrict to a few specially licensed doctors the ability to prescribe heroin, dipipanone and cocaine for the treatment of addiction.

Other relevant legislation in the field of drug misuse

The Medicines Act 1968 (equivalent to Canada's *Food and Drugs Act*) regulates the production and distribution of medicinal drugs and other medicinal products in the UK. It generally requires a marketing authorization or licence before a product may be distributed. The Act deals with the testing, sale, supply, packaging, labelling, prescribing, dispensing by pharmacists, and selling in shops of medicinal products. Many controlled drugs are also medicinal products and must thus satisfy the requirements of both the MDA and the Medicines Act 1968.

The MDA prohibits the importation or exportation of a controlled drug unless it is exempted by regulation or it takes place under the proper licence. The offences, however, are actually under the Customs and Excise Management Act 1979 which acts together with the MDA to prohibit unauthorized importation or exportation of controlled drugs. The offences under the Customs and Excise Management Act 1979 are usually charged and prosecuted by H.M. Customs and Excise rather than by the police and Crown prosecutors. In 1997, a total of 1,741 people were dealt with for

these offences, 68% of which involved cannabis (31% were dealt with by compounding and of those found guilty by the courts, 79% were sentenced to immediate custody).

Part II of the Criminal Justice (International Co-operation) Act 1990 controls the manufacture and supply of certain precursor chemicals which can be used in the manufacture of illicit drugs. Manufacture or supply contrary to the Act is a trafficking offence for the purposes of the Drugs Trafficking Act 1994. Regulations may be made dealing with notification of exports, record-keeping and the supply of information.

The Drug Trafficking Act 1994 was adopted to enable the UK to meet its obligations under the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1998 (The Vienna Convention). It creates offences in connection with laundering and handling of the proceeds of drug trafficking, and introduces confiscation measures. The burden of proof is placed on the defendant to prove that the assets were lawfully acquired and applies the civil standard of proof on the balance of probabilities. The MDA does not distinguish between trafficking and non-trafficking offences. Rather, this distinction is made in the Drug Trafficking Act 1994; the main consequence of designating an offence as a trafficking offence is that the confiscation provisions apply. In addition, an offender is liable for a third trafficking offence involving a Class A drug to a minimum penalty of seven years imprisonment under the Crime Sentences Act 1997.

Debate in the UK

As in Canada, the debate in the UK regarding cannabis would appear to revolve around two issues: (1) decriminalization or legalization of cannabis for recreational use; and (2) the medicinal use of cannabis.

Although cannabis is now a Class C drug, its recreational use is still prohibited in the UK. Under the MDA, it is illegal to grow, produce, possess, or supply cannabis to another person. It is also an offence to allow premises to be used for growing, preparing, supplying or smoking it. Maximum penalties for cannabis offences in the UK are fairly severe (these vary throughout the EU). As in Canada, there is considerable discretion in how the law is applied and in many cases the police caution those found in possession of small amounts of cannabis. In the *Report of the Independent Inquiry into the Misuse of Drugs Act 1971, Drugs and the Law*, the following was stated regarding the use of discretion, particularly with respect to cannabis:

> *Many cases are kept away from the courts by cautioning and compounding and, in Scotland, warning letters and fiscal fines. By far the largest increase in police cautioning in England and Wales has been for cannabis offenders, from 41% in 1990 to 55% in 1997. This has meant in practice a tripling in the number of cannabis offenders for which a caution was given, from 16,500 to 47,000. Cautions are part of an offender's criminal record. There is no provision at present for these records to expire under the Rehabilitation of Offenders Act 1974. The Government has recently issued a consultation paper proposing that this anomaly should be corrected and that cautions should be immediately spent. This*

> *would also apply to reprimands and warnings, which are to replace cautions for young people under 18 under the Crime and Disorder Act 1998.*
> *Cautioning is not used by H.M. Customs and Excise or in Scotland. For importation and exportation offences, compounding – a monetary penalty in lieu of prosecution – may be used in cases involving cannabis not exceeding 10 grams in weight. While compounding does not necessarily become part of an offender's criminal record, it may be mentioned in subsequent court proceedings Its use for cannabis importation offenders fell between 1990 and 1997 from 58% to 45%.*
> *...This discretion in the implementation of the MDA is desirable but produces anomalies in the differing regimes of cautioning and compounding, and inconsistencies in the cautioning rates between police forces. More than half of the arrests for cannabis offences result in a caution. We do not criticise the police for their extensive use of cautioning. It is currently the only realistic and proportional response. Without it, the courts would have ground to a halt. However, the use of discretion does not lessen the disproportionate attention that the law and the implementation of the law unavoidably give to cannabis and cannabis possession in particular.*[85]

The use of cannabis for medicinal purposes has a long history in the UK. It was prescribed as a medicine in the UK until 1973. At that time, it became a drug that could not be legally used as a medicine and today its medicinal use remains prohibited. As will be discussed in the next section, the Science and Technology Committee of the House of Lords recommended that cannabis be made available for medicinal purposes in a 1998 report. This recommendation was rejected by the government, which indicated that before such a change could be considered, the safety and efficacy of cannabis would have to be demonstrated. G.W. Pharmaceuticals has been given permission to grow cannabis with the aim of developing a cannabis-based medicine; clinical trials have commenced in the UK.

Recent key reports and studies

Science and Technology Committee of the House of Lords

In 1998, the Science and Technology Committee of the House of Lords studied the issue of medicinal use of cannabis and tabled a report entitled Cannabis: The Scientific and Medical Evidence. The purpose was to examine the scientific and medical evidence with respect to the medicinal use of cannabis and determine whether current restrictions were appropriate. In addition, the Committee considered whether the prohibition on recreational use was justified based on the scientific evidence of adverse effects. However, the mandate did not include other issues such as the social and legal aspects of cannabis use.

The Committee discussed the long history of cannabis use both as a medicine (usually in the form of a tincture) and an intoxicant. The Committee noted that the

---

[85] Police Foundation (2000) *Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, "Drugs and the Law", Chapter 7, paragraphs 28, 29 and 31.

"*advent of a host of new and better synthetic drugs led to the abandonment of many ancient herbal remedies, including cannabis.*"[86] The *Medicines Act 1968* allowed the government to licence pharmaceutical companies and products, and cannabis was still able to be prescribed under certain conditions. In 1973, cannabis's licence of right was not renewed and the regulations under the *Misuse of Drugs Act 1971* prohibited medical use altogether (by listing cannabis in what is now Schedule 1).

The Committee then went on to review the pharmacology of cannabis and the different ways it may be administered, the toxic effects of cannabis, including: the short and long-term effects of it; whether the user develops tolerance to the drug; and whether it causes dependence. The Committee found that although cannabis "*is not in the premier league of dangerous substances, new research tends to suggest that it may be more hazardous to health than might have been thought only a few years ago.*"[87]

Concerning the current medical use of cannabis in the UK (quite widespread even though it is illegal) as well as the current medical uses of cannabinoids (certain cannabinoids are legally in current use in UK medicine), the Committee proposed new indications for cannabis-based medicines (including alleviating certain symptoms related to multiple sclerosis). The Committee stated that it "*is important to distinguish the different substances and preparations; for instance, cannabis leaf must be distinguished from cannabis extract, and whole cannabis from THC. It is also important, although not always easy, to distinguish the various possible routes of administration, e.g. by smoking and by mouth.*"[88]

Based on evidence that cannabis can be effective in relieving the symptoms of multiple sclerosis and against certain forms of pain, the Committee recommended that clinical trials of cannabis for these conditions "be mounted as a matter of urgency." The Committee members did indicate that if a medicine became licensed (after clinical trials), they did not envisage smoking being used to administer it. Thus, they called for research into alternative delivery systems. The Committee also recommended that cannabis should be reclassified as a Schedule 2 drug so that doctors would be permitted to prescribe an appropriate preparation of cannabis, "*albeit as an unlicensed medicine and on the named-drug basis*"; this would also allow research without a special licence.

Compassion was the main reason for recommending the change to the law (a law under which patients risk prosecution to get help). Another reason was the inconsistent way in which the law was enforced, which brought it and Parliament into disrepute.

The Committee did note that cannabis-based medicine would not be appropriate for certain groups of patients such as pregnant women, people predisposed to schizophrenic illness or those with cardiovascular conditions. In addition, users would have to be warned of possible side-effects. The risk of addiction would have to be considered when deciding whether to prescribe. Thus, the Committee recommended that "*if doctors are permitted to prescribe cannabis on an unlicensed basis, the medical professional*

---

[86] House of Lords, Select Committee on Science and Technology, Ninth Report, Session 1997-98, *Cannabis: The Scientific and Medical Evidence*, para. 2.6.

[87] *Ibid.*, par. 4.1.

[88] *Ibid.*, par. 5.1.

bodies should provide firm guidance on how to do so responsibly"[89] and that "*safeguards must be put in place by the professional regulatory bodies to prevent diversion to improper purposes.*"[90]

With respect to the recreational use of cannabis, the Committee added that although the harms must not be overstated, there was enough evidence of toxic effects of cannabis to justify maintaining the current prohibition.

The government rejected the recommendation to reclassify cannabis. It indicated that before cannabis should be available for prescription, its safety, quality and efficacy would have to be demonstrated and a marketing authorization issued by the Medicines Control Agency. In addition, the government indicated that allowing prescriptions of cannabis would reduce momentum in research. The government was also concerned with the possibility of prescribed cannabis being used for improper purposes.

In March 2001, the Science and Technology Committee of the House of Lords presented another report dealing with the current state of research into the therapeutic uses of cannabis, the roles of the Home Office and the Medicines Control Agency in the licensing of cannabis-based medicines, and more recent issues relating to the prosecution of therapeutic cannabis users. The Committee reiterated that cannabis should remain a controlled drug and that the legalization debate should maintain a clear distinction between therapeutic and non-therapeutic use.

With respect to the current state of research, the Committee noted trials recently approved for funding by the Medical Research Council. The Committee was concerned about the long timeframe for developing usable therapeutic preparations from these trials. It was more encouraged with the progress being made by G.W. Pharmaceuticals, both with respect to establishing the efficacy of a cannabis-based medicine and in developing suitable medical preparations (e.g., a sub-lingual spray).

The Committee also discussed the prosecution of therapeutic users of cannabis. They noted that the decision to prosecute varies from region to region and that, in some cases, juries have acquitted therapeutic users who do not deny the offence but plead therapeutic use in mitigation while others are found guilty. The Committee believed that the acquittal of cannabis users by juries on compassionate grounds brings the law into disrepute. According to the Committee, this problem underlines the need to legalize cannabis preparations for therapeutic use.

The Committee noted that the decisions made by the Medicines Control Agency appear to be inconsistent. For example, although it is satisfied that the information on the toxicological profile of delta-9-tetrahydrocannabinol is adequate, it is not satisfied with the toxicology data of cannabidiol. The Committee was of the view that the Medicines Control Agency had "*not adopted a positive approach towards the licensing of a cannabis-based medicine.*" The Committee was concerned that the Medicines Control Agency's approach places "*the requirements of safety and the needs of patients in an unacceptable*

---

[89] *Ibid.*, par. 8.16.

[90] *Ibid.*, par. 8.17.

balance." The Committee concluded that the Agency's attitude "*means that cannabis-based medicines are not being dealt with in the same impartial manner as other medicines.*"

> *We believe that a thorough and impartial reappraisal of the published scientific literature on the safety of CBD and cannabis extracts should lead the MCA to reconsider their present overly cautious stance. We are at least encouraged that the MCA state that they are conducting a more detailed review of existing literature reports on cannabis and CBD.* [91]

The Runciman Report

In August 1997, The Police Foundation set up an independent inquiry (chaired by Viscountess Runciman) to assess the UK's legislation on the misuse of drugs. The main goal was to determine whether the legislation needed to be revised in order to be more effective and more responsive to the changes that had taken place in the 30 years since the original law was passed.

The report recognizes that the goal of drug legislation must be to control and limit the demand for and the supply of illicit drugs because eradication of drug misuse is not a realistic goal. The report also stated that the law must fulfil UK's international obligations and noted that international agreements – while restricting some options – allow for room to manoeuvre, particularly in the areas of drug use and possession.[92] The report discussed different approaches towards drug use and possession and towards minor acts of supply taken by some other European countries and found that the UK had a comparatively more severe regime of control of possession offences.

The report indicated that the law should be based on the following principles:

- as a means of reducing demand, the law is only one aspect of a broader agenda of health, prevention and education;
- it should reflect the latest scientific understanding and the social and cultural attitudes of modern British society;
- it should be realistically enforceable;
- it should infringe personal freedom only to the degree necessary to restrain serious levels of harm to users or others;
- it should target the drugs that cause the most harm;
- it should reflect the relative harmfulness of activities connected with each illicit drug or category of drugs, and provide for sanctions proportionate to that harm; and
- in its operation, the law should be accepted by the public as fair, consistent, enforceable, flexible and just.

---

[91] House of Lords, Select Committee on Science and Technology, *Therapeutic Uses of Cannabis*, Second Report, March 14, 2001, par. 29.

[92] *Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, Drugs and the Law, Mars 2000, page 74.

The report noted a steady increase in the prevalence of both problem drug use (including injecting among problem drug users) and casual drug use in the UK over the past 30 years. Cannabis is the most widely used illegal drug, with age 30 being the big divide in drug use. Despite there being a steady rise in drug offences and seizures (including amounts seized) over the years, the report concluded that efforts to limit supply have in the most part failed. The report found that the public views health-related dangers of drugs as more of a deterrent than their illegality, availability or price. In addition, public attitudes to cannabis compared to other drugs were significantly different (cannabis was seen as the least harmful drug, its possession should be the lowest of priorities for police, and a number of people – a third to half – believe that the laws should be relaxed).[93] All age groups shared these views, although support for legalization was not as strong among older age groups. With respect to other drugs, strong drug laws were fully supported despite concern with health risks resulting from drug use. The public was much more concerned with trafficking than with possession offences. The inquiry found that there was a lack of data on drug use and the absence of detailed cost information about drug use (e.g., health care, enforcement and other social services costs). Thus, it was difficult to do any type of assessment of drug control and prevention strategies

The UK's drug classification was reviewed and the report recommended keeping the current three-tier drug classification system (class A, B and C). This classification enables authorities to distinguish between the relative risks of different drugs and allows sanctions to be applied that are proportionate to a drug's harm. However, the report found that the criteria by which drugs are classified should be clearly described. The classification should take into account modern developments in medical, scientific and sociological knowledge; as well, the main criteria should be dangerousness of the drug to the individual and to society. The report set out factors to consider, including: the risks of the drug itself (acute and chronic toxicity); risks due to the route of use; extent to which the drug controls behaviour (addictiveness/dependency) and ease of stopping; and social risks (costs to society in terms of crime, medical costs, social harm through intoxication, etc.). Based on these factors, the report recommended some changes to the drug classes to counteract what the members felt was a dangerous message, i.e., that all drugs are equally dangerous. The members of the inquiry believed that these changes would enhance the law's credibility and that education and attention should be refocused on the more harmful drugs such as heroin and cocaine. The report recommended the following changes:

- cannabis should be reclassified from a class B drug to a class C drug and cannabinols from class A to class C;
- heroin and cocaine would remain in class A (the most dangerous drug category) while Ecstacy and LSD would move to class B; and
- buprenorphine would move from class C to class B.

[93] *Ibid.*, Chapter 2, par. 64.

It is interesting to note that the members of the inquiry would have classified alcohol as a class B drug bordering on A, while tobacco would have been on the borderline between B and C, if these substances were controlled under the MDA.

The report found that possession offences should remain, even if for personal use. However, the law should minimize the harmful consequences of a contravention in appropriate cases. The report concluded that for the majority of possession offences, imprisonment was neither proportionate nor effective. It recommended that imprisonment no longer be available for possession of class B or class C drugs. Imprisonment should remain a possibility for possession of class A drugs, although the maximum would be shorter than what is currently set out. This would reflect what the courts are currently doing; the average possession sentence is fairly short compared to the maximum available. In addition, the report recommends lowering the maximum fines for all classes of drugs. According to the report, imprisonment for possession would be rare. Non-custodial responses would include fines, probation orders, probation orders with treatment conditions attached, and conditional discharges. These sanctions would be most suitable for possession of class B and class C drugs where a caution was not appropriate. The report noted that in over 50% of cases, police use cautioning. This approach was supported but the report felt that this discretion needed a proper framework. Thus, cautions should become a statutory sanction with guidelines set out in regulations. This would allow the enforcement of conditions attached to a caution. Finally, the report recommended that a caution should not carry a criminal record. If the recommendation to reclassify cannabis as a class C drug were carried out, it would have certain consequences, including that police would no longer be allowed to arrest for possession of cannabis. For arrestable offences, the police have powers to insist that suspects accompany them to the police station and to search their premises without a warrant. Police would still have the power to stop and search for all drugs, however.

With respect to trafficking, the report mentioned that there should be an attempt to differentiate between acts of different gravity with respect to supply offences (for example, supply between friends versus as part of an organized criminal group and supply of class A drugs versus other drugs). The report recommended a separate offence of dealing, the main ingredient of which would be the pattern of activity of illicitly transacting business in drugs. The offence would be a trafficking offence for the purposes of the Drugs Trafficking Act 1994. The report also recommended that the maximum penalty for trafficking in class A drugs be lowered to 20 years and that the maximum for class C drugs (including cannabis) be raised to seven years. The report also recommended the adoption of sentencing guidelines, for trafficking offences in particular. The report also mentioned the ineffectiveness of the laws dealing with confiscation of assets (in their view, a pragmatic problem rather than a legislative one). The report recommended improving the effectiveness of the current system by setting up a new national confiscation agency and making several other changes.

Although the inquiry members believed that the drug legislation in general did not need radical change, the legislation's application to cannabis was the exception. Thus, many of the more significant changes apply to this drug. The report noted that it was the drug most widely used and most likely to bring people in contact with the justice system. The report also noticed the gap between how the law is written and how it is practised with respect to cannabis (due to the use of discretion). The members of the inquiry were of the view that cannabis was less harmful to the individual and society than other illicit drugs (although not harmless). With respect to cannabis, it was felt that the current law produces more harms than it prevents and that the law's response is disproportionate to the drug's harm. The report, thus, recommended penalties for cannabis possession for personal use be decreased and that imprisonment not be an option (normal sanctions for possession and cultivation for personal use would be out-of-court disposals, including informal warnings, statutory cautions or a fixed out-of-court fine). In addition, the report stated that cultivation of small amounts of cannabis should be prosecuted under section 6 (cultivation of cannabis) rather than section 4 (production) so that it not be considered a trafficking offence. The cultivation offence should be treated in the same way as possession of cannabis. In addition, permitting people to smoke cannabis on their premises would no longer be an offence. The members of the inquiry were of the view that the benefits of such a strategy outweigh the risks and that this would promote the targeting of enforcement on those drugs and activities that cause the most harm.

The report concluded that demand is not significantly reduced by the deterrent effect of the law. Education and treatment can be successful, however. Thus, the members recommended a less punitive approach to possession offences and a more punitive approach to trafficking (particularly with respect to profits obtained from drugs). The members believed that harm could be reduced with credible education and treatment when needed. They indicated that treatment is cost-effective in reducing problem drug use and associated criminal activity and recommended a substantial reallocation of resources from enforcement (currently 62%) to treatment (currently 13%).

With respect to the medicinal use of cannabis, the report concluded that the therapeutic benefits of cannabis for certain serious illnesses outweighed any potential harm. They endorsed the view of the House of Lords report that cannabis and cannabis resin should be moved to Schedule 2 (thus permitting possession and supply for medical purposes). Because the House of Lords recommendation was rejected by the government and because it would be years before a licensed cannabis product becomes available, the report recommended a new defence in law: duress of circumstance on medical grounds for those accused of the possession, cultivation or supply of cannabis for the relief of certain medical conditions.

In its reply to the report, the government rejected or referred for further consideration many of the recommendations made by the inquiry. On the key issues of reclassifying cannabis and the depenalization of cannabis, the government did not

support the inquiry's recommendations. With respect to the reclassification of cannabis, the government was mainly concerned with the health risks associated with its use. With regard to depenalization, the government rejected removing imprisonment as a possible sanction. In addition, they did not want the police powers of arrest to be abolished for these offences. In dealing with the medicinal use of cannabis, the government indicated that the quality, efficacy and safety of a medicinal form of the drug must be established before prescribing should be allowed.

As we now know, the government has since reclassified cannabis and abolished prison terms for possession for personal use.

Other reports

A Working Party of the Royal College of Psychiatrists and the Royal College of Physicians also published a report in 2000. Entitled *Drugs: Dilemmas and Choices*, the report examined key issues in preventing drug misuse. In particular, it states:

> *Spending on prevention: Three-quarters of UK expenditure is devoted to enforcement and international supply reduction. There is little evidence that this is money well-spent. The proven cost-effectiveness of methadone maintenance and abstinence-based programmes for heroin addicts suggests that more of the available budget should go to treatment programmes. New money for treatment announced by the Government is welcome, but calls for expansion of unproven and untested treatments must be resisted.*
> *Research: Current UK expenditure on drugs research does not begin to match the magnitude of the problem. Just one per cent of the annual drugs prevention budget would inject £14 million into research – over double the current spent.*
> *Improving the value of treatment: Systematic investment in staff training, monitoring of patients and essential support services is needed to bring improvement rates achieved by UK treatment programmes closer to those in the United States. In particular, more extensive drug treatment facilities are needed for adolescents.*
> *Private prescribing: Private prescribing of substitute drugs leaves scope for malpractice that comes close to 'buying a prescription'. Doctors treating drug-users outside the health service are not currently required to have extra training in addictions and receive little monitoring or regulation.*
> *Drug-testing by employers: Although expensive and surrounded by legal and ethical issues, the technology exists for drug-testing of employees using hair samples. This provides a record of drug-use over the previous three months and could, therefore, have a major impact on the prevalence of drug-use in future.*
> *Ecstasy: Many young people use Ecstasy, and some drugs education campaigns may have proved counter-productive. Any advice given to young people should take account of the likely impact on those who continue to use drugs as well those who will be deterred.*
> *Amphetamine: Dependence on amphetamine, especially when injected, probably carries more risk to users and public health than heroin. Little research has been carried out into dependence or treatment.*
> *Cannabis: Cannabis is not a harmless drug, but its ill-effects on health are almost certainly less than those of tobacco or alcohol, which are legal. More research is needed into the medicinal benefits and long-term ill-effects of the drug. Legislative experiments, as in the Netherlands, should be encouraged. People requiring cannabis to relieve disabling medical conditions, such as multiple sclerosis, should not be prosecuted.*

> *Future policy: The Government's Ten-Year Strategy for Tackling Drug Misuse recognises the need for greater investment in treatment. But there are no easy answers, and ambitious targets for reducing the proportion of young people using heroin and cocaine by 50 per cent by 2008 are unlikely to be achieved by the modest initiatives announced so far. Attempts to curb the illegal international drugs trade have consistently failed and will probably continue to do so. If the prevalence of drug-use and drug-related crime continues to rise, the pressure on the UK and other governments to change policies that are clearly failing is bound to increase.*[94]

Administration

Because of the complexity of the drug problem, many different departments and organizations are involved in implementing the UK drug strategy. The key organizations in the UK's drug strategy are the drug action teams at the local level, which are responsible for ensuring that the strategy is translated into concrete action.

Costs

Public costs

In 1997/1998, most of the costs were directed at enforcement. The total expenditure of £1.4 billion was spent on the following activities:

- *drug misuse, enforcement and international supply reduction* accounted for 75% (enforcement includes police, court, probation, and prisons – 62%; international supply, which encompasses customs and excise, Foreign and Commonwealth Officer – 13%);
- *treatment and rehabilitation*–13%; and
- *education and prevention*–12%.[95]

Following a comprehensive spending review in 1998, an additional £217 million were to be allocated over a three-year period to drug activities. "A substantial share of these new funds will be directed at initiatives designed to break the link between drug misuse and crime, including Arrest Referral Schemes and Drug Treatment and Testing Orders. The idea is to provide every drug misusing offender entering a police station or prison with a chance to seek treatment by the year 2002."[96] The extra funds were to be spent as follows:

- £133 million for the implementation of the strategy to tackle drug misuse in the criminal justice system.

---

[94] Joseph Rowntree Foundation, *Drugs: dilemmas, choices and the law*, November 2000. This article may be found at http://www.jrf.org.uk/knowledge/findings/foundations/N70.asp.

[95] *Tackling Drugs to Build a Better Britain, The Government's Ten-Year Strategy for Tackling Drugs Misuse*, April 1998, in the chapter entitled: "Resourcing and Managing the Work".

[96] DrugScope, *UK Drug Situation 2000*. The UK Report to the European Monitoring Centre for Drugs and Drug Addiction, November 2000, page 7.

- Prisons would receive £60 million for treatment services and £12 million for voluntary drug testing in prisons.
- £61 million for the piloting and implementation of Drug Treatment & Testing Orders.
- £70.5 million would be allocated to health and local authorities to fund new treatment services and to improve community care for drug misusers.
- Health Authorities would receive £50 million for treatment services and for young people at risk.
- Local Authorities would receive £20.5 million to improve access to services and increase numbers in treatment programs.
- £10.5 million would be allocated to support Drug Action Teams across the country and for national research into effectiveness of anti-drugs activity.
- £3 million would be allocated to support cross-departmental development of more effective drugs education.
- £6 million over 3 years would be provided for a major new research program.
- An extra £3 million would be available from the Confiscated Assets Fund in 1999/2000, to be increased to £5 million and £7 million in subsequent years.[97]

Social costs

The UK Anti-Drugs Co-ordinator's Annual Report 1999/2000 stated that drug misuse costs Britain over £4 billion per year in crime, sickness and absenteeism. In addition, it was estimated that one-third of property crime is related to drugs.

Statistics

The Office for National Statistics estimates that the illegal drugs market alone accounts for nearly 1% of national output, equivalent to £8.5 billion a year.[98]

Despite the criticisms made in certain reports, the UK has an impressive database on drug use trends. Every two years since 1983, the Home Office has conducted the national British Crime Survey, which includes a series of questions on illegal drug use. The Home Office also keeps detailed data on arrests, convictions and sentences. The *DrugScope* organization is the British correspondent for the OEDT.

Use

In the 16-59 age group, 32% in England and Wales say they have "ever used a drug" (1996 = 29% and 1994 = 28%). This rises to 50% for the 16-24 age group.

[97] *Ibid.*, page 11-12.

[98] "The Untouchables", *Economist*, April 21, 2001, Vol. 359, No. 8218, page 49.

Recent drug use was less common, however. For example, in the 1994, 1996 and 1998 surveys, 10%-11% reported drug use in the last year and 6% reported drug use in the last month. Drug use does change with age: 30% of 16- to 24 year olds reported drug use in the last year and 20% in the last 30 days (this compares to 3% and 1.5% for 45-to 54 year olds). In addition, there is a higher prevalence of drug use in males than in females. With respect to children, surveys in England show that 13% of respondents aged 11 to 15 reported ever taking a drug. For children, prevalence increases with age. For example, 3% of 11- to 12-year-olds, 13% of 13- to 14-year-olds, and 31% of 15 year-olds reported ever using drugs.

Cannabis is the most widely cultivated, trafficked and used illicit drug in the UK. The young use it most commonly, with usage declining with age. Almost half of 16- to 24 year olds in England and Wales report ever using cannabis, with 17% using it in the last month. Only 5% of adults aged 55 to 59 report ever using this drug.

Offences

As stated, people arrested in the UK may be dealt with in different ways including cautioning by police or prosecution (except in Scotland where other procedures are available). Under the Customs and Excise Act 1979, compounding (the payment of a monetary sum in lieu of prosecution) is available in cases of importation of small quantities of cannabis (10 grams or less). In addition, the authorities may use their discretion and take no further action. This last option would not appear in criminal statistics.

The total number of people dealt with for drug offences went from 35,000 in 1988 to 153,000 in 1998. Of these, 127,840 were found guilty, cautioned, fined or settled with by compounding. In 1997, the number was 113,150. The most common drug was cannabis at 76%. Almost 90% of MDA offences are possession offences and, generally, three-quarters of all possession offences involve cannabis. The number of people who receive cautions has increased dramatically over the years and of the people found guilty, cautioned, fined or settled with by compounding, cautioning now accounts for almost 50%. Thus, many of the cases are dealt with outside the courts.

In 1998, the number of drug seizures was 149,900, an 8% increase over 1997. Cannabis was involved in 76% of the cases. Between 1995 and 1999, the average price of most drugs remained relatively stable.

SWEDEN[99]

When contrasting a successful model with the Dutch "failure", the witnesses we heard invariably mentioned Sweden. In Sweden, the drug phenomenon is considered one of the most serious social problems (if not the most serious), and drugs are viewed as an external threat to the country.[100] Drug addiction is often viewed as the cause of other social problems and the drug problem itself as jeopardizing Sweden's traditional values. These concerns have intensified since Sweden became a member of the European Union (EU) in 1995, since most of the other members of the EU have adopted a more liberal attitude on drug issues. In comparison to other western European countries, Swedish drug policy is regarded as restrictive. One of the aims of the policy is to make it clear that drugs are not tolerated in society, and its overall goal is a drug-free society. In particular, we observe that:

- harm reduction programs are available in a limited fashion only;
- treatment is based on obtaining complete abstinence and it is possible to force people into treatment;
- drug use is an offence, and urine and blood tests are used to detect those suspected of drug use;
- drug legislation is strictly enforced;
- discussions regarding the medical value of cannabis are almost non-existent;
- Swedish legislation strictly adheres to, and even exceeds, the requirements set out in the three United Nations drug conventions.

While Swedish drug policy is currently very restrictive, this was not always the case. In fact in the 1960s, its policy was fairly liberal, basically reflecting a harm reduction approach.[101] For example, from 1965 to 1967, it was possible for severe drug abusers to obtain prescriptions for morphine and amphetamines. This non-scientific experiment (involving approximately 120 people) was used by Nils Bejerot, a police doctor and very influential figure in Swedish drug policy, in his study of the relationship between drug use and drug policy in the period between 1965-1970. Some of his

---

[99] This section draws to a large degree on the report prepared for the Committee by the Library of Parliament: G. Lafrenière, (2001) *National Drug Policy: Sweden*. Ottawa: Library of Parliament, report prepared for the Senate Special Committee on Illegal Drugs, available online at www.parl.gc.ca/illegaldrugs.asp. For more information, see also T. Boekhout van Solinge, (1997) *The Swedish Drug Control System: An in-depth review and analysis*, Centre for Drug Research, University of Amsterdam, Amsterdam, 1997.

[100] European NGO Council on Drugs and Development, *A Snapshot of European Drug Policies : Report on the state of drug policies in 12 European countries*, October 2001, page 27.

[101] United Nations Office for Drug Control and Crime Prevention, *Country Drug Profile : Sweden*, 1998, page 1.

findings included: that changes from restrictive to permissive policy and vice versa was reflected in the rates of intravenous drug use; that this experiment was the origin of the Swedish drug epidemic; and that the experiment did not have the desired effect of crime reduction. His findings are still widely accepted in Sweden even though they have been criticised.[102]

With increased drug use in 1965, the Committee on the Treatment of Drug Abuse was established: it published four reports from 1967 to 1969. The first report dealt with treatment and the second with repressive measures. It is this second report which led to the adoption of the *Narcotic Drugs Act* in 1968. The Committee's reports indicated that the drug problem was on the increase. This finding, in conjunction with the findings of Bejerot, are partly responsible for the more restrictive approach adopted by Sweden in the late 1960s. In addition, since 1968, the government organized a massive media and school campaign against drugs. This led to a generation growing up with messages based on the gateway theory, among others.[103] This theory is used as a justification for being restrictive in relation to cannabis and "*Swedish drug policy actually focuses on cannabis, since it is alleged 'drug careers' start with this substance.*"[104] In addition, the dangers caused by cannabis itself (psychosis, addictive character, higher risk of suicide, etc.) are seen as reasons for having a restrictive policy.

Over time, Swedish policy became more restrictive and repressive, resulting in the strengthening of penalties, criminalizing of use, and allowing of urine and blood tests for those suspected of use. Although the original goal of the urine and blood tests was to detect new users and provide them with appropriate treatment, it would appear that the tests are no longer being used for this sole purpose as known drug users are also being targeted.[105]

Some authors have drawn a link between Sweden's restrictive drug policy and its restrictive alcohol policy. The temperance movement has a long history in Sweden and the country has developed a fairly restrictive alcohol policy, including a state monopoly on the sale of alcohol.

> *Swedish attitudes towards alcohol are relevant since a restrictive alcohol policy makes a restrictive drug policy a logical option. Moreover, the total consumption model on which the alcohol policy is based, is thought to be valid for illicit drugs as well. By limiting the total consumption of drugs, the total harm caused by drugs is alleged to be lower as well. However, it was shown that this correlation is far from clear when it comes to (different) illicit drugs.*[106]

---

102 Boekhout van Solinge, *op. cit.*, page 45.

103 European NGO Council on Drugs and Development, *op. cit.*, page 27.

104 Boekhout van Solinge, *op. cit.*, page 88.

105 *Ibid.*, page 116-117.

106 *Ibid.*, page 103.

National strategy

Following the creation of a Commission on Narcotic Drugs, the Swedish government presented a new action plan in January 2002, which is to be valid until 2004. A total of SKR 325 million (approximately $50 million Canadian) has been allocated over the three-year period to combat illegal drug use. The action plan was presented as a means to reverse the disturbing trend in drug abuse. [107]

The policy's objectives are to:

- reduce the number of new recruits to drug abuse (mainly through prevention directed at young people);
- encourage more drug users to give up the habit (through care and treatment); and
- reduce the supply of drugs (through criminal measures).

One of the key new features of the drug strategy is the creation of a national anti-drugs coordinator position. The position was created to have clear leadership in the drug policy area, make it possible to follow up on the plan's goals, and determine whether new initiatives are required to combat new problems. The key tasks for the new anti-drugs coordinator are to:

- develop cooperation with authorities, municipal and county councils, NGOs, etc.;
- shape public opinion;
- undertake a supporting function for municipal and county councils in the development of local strategies;
- initiate methods development and research;
- serve as the Government spokesperson on drugs issues;
- evaluate the action plan; and
- report regularly to the Government (at least once a year).

Of the SKR 325 million, 100 million (approximately $15 million Canadian) has been allocated to a special drugs initiative within the Swedish Prison and Probation Service. The goal is to offer care and treatment to all drug abusers in this system. In addition, the National Prison and Probation Administration is required to:

- develop methods for preventing drugs being brought into institutions and detention centres;
- investigate the obstacles to treatment outside institutions; and
- produce special programmes for contract care, i.e. care in accordance with a contract between the person convicted and the community.

[107] Ministry of Health and Social Affairs, *National Action Plan on Narcotic Drugs*, Fact Sheet, February 2002.

With respect to the police, the National Police Board and the National Council for Crime Prevention will be required to carry out their own review of police efforts to combat drug-related crime.

In Sweden, while the national policy is created at the national level, much of the responsibility for implementing the goals of the action plan remains with the municipalities. For example, they have responsibility for the care of drug abusers pursuant to the *Social Services Act*. In addition, prevention initiatives are also carried out at the local level. Thus, strategies in municipalities will be based on local concerns. Enforcement of the legislation remains at the national level, however, through the police and customs services.

Treatment is one of the three pillars of Sweden's drug policy. One of the stated goals of Swedish drug policy is to rehabilitate the user rather than to punish them by way of the criminal justice system. Since 1982, it has been possible to force people into drug treatment (also applies to alcohol and other products) for a period of up to six months. The main reason for this type of treatment is to protect the user or others in cases of life threatening situations and to motivate the user to continue treatment on a voluntary basis. The use of compulsory treatment appears to be uncommon and its effectiveness has been questioned.[108] In the last several years, there has been a shift from compulsory treatment and institutional treatment towards out-patient treatment. It would appear, however, that treatment is less easily available today than it was 10 to 15 years ago. In addition, the time a user spends in treatment has shortened. These changes are due to cutbacks in social service spending at the municipal level that occurred in the 1990s. "*Whereas in 1989 there were 19,000 people in treatment centres (for both alcohol and drugs), in 1994 this number had dropped to 13,000. In the same period, the number of people in compulsory care dropped from 1,500 to 900. Due to the budget cuts, 90 treatment homes were closed between 1991 to 1993.*"[109]

Methadone substitution programs have been available in Sweden since the end of the 1960s. Currently, approximately 600 people are involved in methadone substitution programs in Stockholm, Uppsala, Malmo and Lund. The programs are strictly regulated and are officially viewed as being experimental. Some of the conditions for participation include that: the patient must be aged over 20 and demonstrate at least four years of intravenous opiate abuse; he or she must have tried several forms of drug-free treatment; the person in question must have entered the program on a voluntary basis (for example, the person must not be detained, under arrest, sentenced to a term of imprisonment or be an inmate of a correctional facility). For those participating in methadone substitution programs, other drugs are not permitted and the patient must visit the clinic on a daily basis. At this time, the maximum number of people that may be in the program at one time is 800. Pilot projects are under way with Subutex.

---

108 Boekhout van Solinge, *op. cit.*, page 165.

109 *Ibid.*, p 125.

While Sweden has spent large sums of money on treatment, few of its programs have been properly evaluated. Therefore, it is difficult to provide details of their effectiveness. "*The official aim is to rehabilitate drug addicts and a lot of effort and financial means are allocated to achieve this; much more than in many other European countries. However, despite all these good intentions, the reality is that the effectiveness of these very expansive programmes is relatively low. In the long run, the Swedish drug treatment programmes do not show better results than what is found internationally.*"[110]

With respect to harm reduction initiatives, there are few low threshold services in Sweden and most are staffed by voluntary organizations. They offer a series of services, but no prescriptions. Needle exchange programs are operated at clinics for infectious diseases in hospitals in Lund and Malmo, and are thus fairly limited. Harm reduction initiatives, such as needle exchange programs, are difficult to promote under a vision of a drug-free society where drug use is not accepted. A proposal in the late 1980s to introduce needle exchange programs throughout Sweden was quashed by Parliament because it "*was felt that a higher availability of needles would not stop the spread of HIV, on the contrary, it was thought to increase intravenous drug use.*"[111]

The criminal justice system also plays a role with respect to treatment. In 2000, more than 5,000 drug users were placed in prison. While in prison, offenders have access to treatment programs for drug abuse and some offenders are transferred outside prison for treatment. There are also initiatives to keep drugs out of prisons, for example by conducting searches and urine tests. While in prison, the offender is not offered syringes and substitution treatments are not available.

Swedish legislation allows, under certain conditions, that a sentence may be served outside prison. The necessity of drug treatment is one of the reasons that is often given. Another alternative to imprisonment is a probationary sentence combined with institutional drug treatment. An example of an alternative to prison is the following:

> *Since 1998, persons with drug addiction problems who have committed a drug offence can access treatment signing a 'treatment contract.' It is a real contract between the drug addict and the Court in which the two parties have rights and obligations like in all contracts. However, certain conditions must be fulfilled by the drug addict: the person must need treatment and he must be motivated to undergo treatment; he/she is a misuser of drugs; and the drug habit contributed to the drugs crime, which should not be serious (less than 2 years foreseen as penalty). The person is not sent to prison and a personalised plan of treatment is established. The health authorities are responsible for the treatment and shall report to the local prison and probation administration and to the public prosecutor if the probationer seriously neglects the obligations stated in the personal plan.* [112]

---

[110] *Ibid.*, page 162.

[111] *Ibid.*, page 129.

[112] European Monitoring Centre for Drugs and Drug Addiction, *Country Profiles – Sweden*, European Legal Database on Drugs, 2001.

With respect to prevention, drug education programs start early and regularly appear throughout the school curriculum. "*Without exaggeration, this opinion-forming could be described as a process of indoctrination. Considering the magnitude of these programmes, the contents of them have gradually become something indisputable and conclusive that one incorporates them into one's own value system.*"[113]

With respect to cannabis, it is viewed as a dangerous drug "*and its use is regarded as the beginning of a career in drugs.*"[114] This is one of the reasons that prevention measures pay specific attention to cannabis as this should lead to less experimenting with the drug and thus prevent new recruits from joining the drug scene.

Legislative framework

Classes of drugs

The main drug legislation in Sweden is the *Narcotic Drugs Criminal Act 1968*. The term "narcotic drugs" is defined in section 8. They include medicinal products or substances hazardous to health with addictive properties and which are subject to control under an international agreement to which Sweden is a party or which the government has declared to be 'narcotic drugs' within the meaning of the Act. No distinction is made between soft and hard drugs. As will be discussed later, the nature of the substance is, however, among the criteria to determine the seriousness of an offence. Narcotic drugs are set out in five lists. List I deals with illegal drugs without medical use; lists II to IV deal with narcotic substances with medical usage and regulation of its import/export; and list V deals with narcotic substances outside international controls. Pursuant to the legislation, narcotic medicines may only be supplied on prescription from a doctor, dentist or veterinarian.

Offences

In Sweden, almost all forms of involvement with narcotics are prohibited pursuant to the *Narcotic Drugs Criminal Act*. This Act lists the behaviours and practices which constitute drug offences and includes possession for personal use, supply (which is fairly broadly defined), manufacture, etc. Even consumption (drug use) has been prohibited since 1988. In this case, "*it is not addiction which is a criminal offence according to this law, but the act of adding a drug to the human body.*"[115] The police are entitled to conduct urine or blood tests in the case of people suspected of having used drugs.

The *Smuggling Criminal Act 2000* regulates illegal import and export of drugs. Other relevant legislation includes: the *Doping Criminal Act 1991* which regulates the importation, supply, possession of performance enhancing drugs for example; the *Act*

---

[113] *Ibid.*, page 177.

[114] Boekhout van Solinge, *op. cit.*, page 15.

[115] N. Dorn and A. Jamieson, *European Drug Laws: the Room for Manoeuvre*, London: DrugScope, 2001, page 188.

on Prohibition of Certain Substances which are Dangerous to the Health 1999 which regulates possession and supply of substances that entail danger to life or health and are being used, or can be used, for the purpose of intoxication – this legislation does not regulate substances regulated by other Acts.

The other relevant laws are: the *Social Service Act 1980*, which covers the possible forms of care for drug users; the *Act on the Forced Treatment of Abusers*, which provides that an addict who is dangerous to himself or to others may be ordered by a court to undergo compulsory treatment (which involves deprivation of liberty for up to six months for adults and even longer for those up to the age of 20). Other legislation deals with possible expulsion from school for students who abuse drugs, revocation of a driving licence for drug addiction, etc. There is zero-tolerance with respect to driving under the influence of drugs.

Penalties

Punishment is determined by rules contained in the Swedish *Penal Code*. There are three degrees of penalties for drug offences: minor, ordinary and serious. Penalties for minor drug offences consist of fines or up to six months' imprisonment, for ordinary drug offences, up to three years, and for serious offences, two to ten years imprisonment. The penalties regulated under the *Smuggling Criminal Act*, are identical to the penalties listed above.

The seriousness of the offence is based on the nature and quantity of drugs and other circumstances. The government has stated that the term "minor drug offence" is to be reserved for the very mildest of offences. For example, it should generally only involve personal use or possession for personal use of very small amounts. In these cases, a fine may be warranted. The fine is based on the offender's income. Minor offences involve: amphetamine up to 6 g, cannabis up to 50 g, cocaine up to 0.5 g and heroin up to 0.39 g; ordinary offences involve: amphetamine from 6.1 g to 250 g, cannabis from 51 g to 2 kg, cocaine from 0.6 g to 50 g and heroin from .04 g to 25 g; and serious offences involve: amphetamine 250 g or more, cannabis 2 kg or more, cocaine 51 g or more and heroin 25 g or more. The trafficking of drugs generally leads to imprisonment.

With respect to smuggling, the determination of the seriousness of the offence considers whether it formed part of an activity pursued on a large scale or on a commercial basis, involved particularly large quantities of drugs or was otherwise of a particularly dangerous or ruthless nature.

In 1996, of the 5,862 people sentenced for drug-related offences, 3,760 were sentenced for minor offences, 1,708 for ordinary offences and 391 for serious offences. Of the 1,274 who were sentenced to imprisonment, 54 were for minor offences, 893 for ordinary offences and 326 for serious offences.[116]

[116] *Ibid.*, page 206.

As in other countries, there are several alternatives to imprisonment. For example, the court can choose other sanctions including probation, conditional sentence or compulsory treatment. These sanctions appear to be used frequently in drug cases.[117]

> *Generally a drug addict who is found guilty of any type of crime can in certain circumstances be ordered to undergo detoxification treatment. Treatment can take place in conjunction with a prison sentence or else together with probation, a conditional sentence or conditional release from prison. The consent of a convicted person to undergo treatment under certain conditions may constitute a reason for ordering probation instead of imprisonment (so-called* contract treatment*). In practice, probation and conditional sentencing in connection with compulsory treatment are usually used for drug offences of* normal *severity, that is in cases where imprisonment would otherwise be imposed.*[118]

Swedish legislation also allows for the forfeiture of any drugs used in the commission of an offence, any gains made, the property used as an aid in an offence, etc.

Prosecutorial discretion

The prosecutor has an absolute duty to prosecute, but there are a number of exceptions. In the Circular of the Prosecutor-General on Certain Questions regarding the Handling of Narcotics Cases, the Prosecutor-General stated that the dropping of prosecutions for narcotic drug offences should be limited to cases involving only possession for personal use of indivisible amounts or corresponding to at most a roll-up of cannabis resin or a dose of some stimulant of the central nervous system, with the exception of cocaine, i.e. such a small amount of a narcotic substance that it would not normally be further divided and sold. Having regard to the difficulties in individual cases of determining the magnitude of this quantity, prosecutions should go ahead in cases of doubt. If circumstances give grounds for assuming that the possession, despite the small amount, is not intended for personal use, the prosecution should not be dropped. As a consequence of these remarks, prosecutions should also not be dropped where an abuser is found in possession of narcotic drugs amounting to personal use for a certain period. In addition, it is of great importance that the dropping of prosecutions should be mainly limited to occurrences of the nature of first offences.[119]

Debate in Sweden

The Swedish vision of a drug-free society is so widely accepted that it is not questioned in the political arena or the media. The drug policy has support from all political parties and, according to the opinion surveys, the restrictive approach receives broad support from the public. For example, a survey in 2001 revealed that 96% were

---

[117] *Ibid.*, page 190.

[118] *Ibid.*, page 191.

[119] European Monitoring Centre for Drugs and Drug Addiction, *op. cit.*

opposed to legalizing any drug that is classified. In addition, another survey in 2000 revealed that 91% were against decriminalizing cannabis use.[120]

> *The role of public opinion is central to understanding the attitude of the different political parties. Opinion polls show that a large majority of the people subscribe to a restrictive drug policy. The same polls indicate that drugs are perceived as one of society's main social problems. The moral panic surrounding drugs is such, that no political party dares to speak out against any measures that may appear to move in the direction of a more liberal drug policy. Supporting the restrictive policy, or even asking for more restrictive measures to curb increase in the drug problem are essential for a political party to win votes. Saying the contrary, to back a more liberal approach, is not an option for a political party and would almost mean its political death. It has been pointed out that anti-drug pressure groups have been the driving forces behind influencing public opinion, and through them the political parties. It has also been shown that besides the social movements, the media have also contributed to the drug scare that exists today and the defining of drugs as a major social problem.*[121]

Thus, the Swedish population in general has a negative view of drug use and is convinced that drugs pose a major threat to society. These themes have been advanced by government, the media and other organizations in Sweden, and others do not often criticize them. Scientists are generally the only group that raises doubts with respect to the current policy.

Recent reports

In 1998, the government created a Commission on Narcotic Drugs. Its mandate was to evaluate Sweden's drug policy and to propose, within the concept of a restrictive drug policy, measures for its strengthening and streamlining. The Commission was not to deviate from the overall aim of a drug-free society. The terms of reference were to:

- propose improvements of methods and systems to assess the drug situation and to evaluate the goal of a drug-free society;
- evaluate and propose measures to strengthen and streamline drug prevention measures;
- analyse the development of treatment programmes, including those in the prison and probation system, and propose measures to improve treatment and rehabilitation of drug abusers;
- evaluate the extent and focus of national funds for the development of treatment and of measures to prevent drug-related crime,
- analyse the need for changes in the working methods in the judicial system and in penal and criminal procedural legislation;

[120] National Institute of Public Health, *National Report: Sweden 2001*, Stockholm, December 2001, page 14.

[121] Boekhout van Solinge, *op. cit.*, page 172-173.

- review existing research, propose how research can be stimulated, strengthened and organized and identify important but neglected areas for research in the drug field;
- frame strategies for targeted information measures and for the formation of opinion.

The Commission recently published a report entitled *The Crossroads* (referring to one direction that calls for a significant increase of resources in the form of commitment, direction, competence and funding and another that implies a lowering of goals and considerable acceptance of drug abuse).

The Commission noted that the drugs issue was not a political priority in recent years. This situation has led to reduced funding for all sectors involved, while the drug problem has become more severe and widespread. The following are some of the Commission's main findings and recommendations.[122]

Leadership: The Commission noted that there is a need for stronger priorization, clearer control and better follow-up of drug policy and of concrete initiatives at all levels of government.

Demand reduction: The Commission noted that there are no hard boundaries between preventive measures, care and treatment, and the restriction of supply. For preventive measures to succeed, they must be "*included in a system of measures restricting availability, and there must be clear rules which include society's norms and values, as well as effective care and treatment.*"[123] The Commission viewed care and treatment as an essential element of drug policy measures as they help reduce drug abuse and also the harm to drug abusers. In addition, the Commission found a need for improving the competence of those in the field of care and treatment. It set out the following guiding principles regarding care and treatment:

- all drug abusers shall be reached by an offer of help and, if necessary, the abuse treated.
- advice, support and assistance shall reach people at an early stage of abuse.
- measures of care shall be aimed at achieving a life free from substance abuse and illegal drugs.
- care and other measures on behalf of substance abusers shall be of good quality.
- measures to combat substance abuse shall be sustainable and long-term.

---

[122] The Swedish Commission on Narcotic Drugs, *Summary of the report The Crossroads from the Swedish Commission of Narcotic Drugs*, Sweden, 2000.

[123] *Ibid.*

Supply reduction: The Commission did not find any real deficiencies in the legislation or the working methods used by drug authorities, although it was vital that these authorities be allocated more resources. Police and customs have not gained control over the illegal market. In fact, indicators show that supply is more generous, prices are lower than in the past and the variety of drugs has expanded. With respect to combating illegal drug trade, the Commission recommended that the organizational structure of the police be examined (for example, the way in which the dissolution of specialized drug squads has affected the quality of police investigations) and that any shortcomings be followed up. The Commission also recommended that special investigation methods (such as controlled deliveries) be reviewed and that the findings lead to the drafting of guidelines on the subject.

Competence development and research: Competence development and research: The Commission was of the view that it was important to improve knowledge concerning different aspects of narcotic drugs, measures used to combat drug abuse and the effect of drug policy.

Costs[124]

As in other countries, systematic figures on drug-related costs are not readily available.

Public costs

Treatment for alcohol and drug abuse has been estimated to cost municipalities SKR 3.7 billion (over $500 million Canadian) per year (55% of which is for institutional care). The police used 6% of its budget to combat drugs during 2000 (for a total of SKR 702 million–over $100 million Canadian). The police had 869 people involved in drug issues while customs had 1,080 involved in border defence. No costs were available for customs.

Social costs

The Commission on Narcotic Drugs estimated the social costs at SKR 7.7 billion per year (does not take into account prevention, training and evaluation).

[124] The following information is based on the European Monitoring Centre for Drugs and Drug Addiction, *National Report – Sweden 2001*, *op. cit.*, page 15.

Administration[125]

As discussed above, the coordinator will now be responsible for coordinating the national drug policy. In the past, this role had been played by the Ministry of Health and Social Affairs. With respect to the legal distribution of narcotic drugs and psychotropic substances, the Medical Products Agency is responsible for issuing authorizations for the import and export of drugs. This Agency also provides drug related statistics to the UNDCP.

The Swedish National Police have responsibility for drug enforcement. The Drug Offences Division of the National Police Board conducts criminal investigations in relation to organized crime, or other drug-related offences, on a national or international scale. The Swedish Customs Service is responsible for points of entry.

The National Institute of Public Health coordinates demand reduction activities. It is also the National Focal Point in the REITOX network. Operational activities are coordinated at the regional and municipal level. There is also local coordination with the participation of social services, the police, prison and probation services, medical services, schools and other concerned parties. Thus, in prevention and care and treatment, local groups and municipalities play a key role.

Because of its encompassing nature, the drug issue also involves many other ministries, for example the Ministry of Justice and the Ministry of Foreign Affairs.

Statistics

Use[126]

Pursuant to surveys among youths in the 9th grade (15-year-olds) and among 18-year-old military conscripts, an obvious trend seen in the 1990s was the increase in lifetime prevalence use of drugs among teenagers, particularly older teenagers. There was also been an increase in recent use (last year, last 30 days) among teenagers and younger adults. For example, the percentage of 15 year olds who had tried drugs rose from 4% to 9% from 1992 to 2000. It is interesting to note that the number was 14% in the beginning of the 1970s and had decreased to around 8% in 1982. With respect to military conscripts, the trend was similar. According to these surveys, consumption of illegal drugs was low compared to other European countries, although the trend pointed to an increase in use. It should be noted that these numbers have been criticized. First, they are applicable to only 15-16 year old students and 18-year-old conscripts. Thus, these prevalence rates did not consider older groups where some first-time experimentation with drugs will occur. In addition, it has been argued that drug use is under-reported when drugs are viewed in such a negative light and the

125 The information in the following section is based on the United Nations Office for Drug Control and Crime Prevention, *Country Drug Profile – Sweden, op. cit.*, page 12.
126 OEDT, *National Report – Sweden 2001, op. cit.*

questionnaires are filled out at school (where some will feel they are being observed by their teachers).[127]

In 2000, the running three-year average of lifetime prevalence for the 15-64 age group was 12% (with the highest at 17% for the 24-44 age group). Since 1988, last year prevalence has never been over 1%. Overall, males are twice as likely to have used drugs than females although the difference is not as high in lower age groups.

Most who have experimented with drugs have tried cannabis, and the majority of these have tried only cannabis (in Sweden, cannabis is usually taken in the form of hashish). The second most popular drug in Sweden are amphetamines. Cocaine would be the third most popular drug for older people, while for youths it would be ecstasy and LSD. During the 1990s, the availability of drugs increased, in particular amphetamine and heroin. It would appear, however, that heroin use is on the increase in Sweden.

In general, the surveys indicate that overall drug use is fairly low in Sweden. With respect to severe drug abusers (defined as intravenous or daily drug use), it would appear that Sweden has a fairly serious problem with a range of between 14,000 and 20,000 people in this class. This is close to the European Union average.[128]

Offences

The number of suspected people reported increased from 6,567 in 1985 to 12,470 in 1999. The police registered 32,423 violations of the *Narcotic Drugs Criminal Act* in 2000, a figure which is similar to the numbers in the previous decade. The number of violations to the *Goods Smuggling Act* has decreased by 85% since 1980, to 350.

In 1998, 92% of these offenders were suspected for use or possession (from 76% in 1975). In addition, the number of those suspected of selling or manufacturing is now 19% (from 40% in 1975).

The number of sentences for violations of the *Narcotic Drugs Criminal Act* or the *Goods Smuggling Act* was 12,470 in 1999 (up from 2,601 in 1975). Cannabis was involved in 51% of sentences in 1998. In 1998, the sentences were divided in the following fashion: 38% were fines; 27% were prison terms; 14% were prosecution waivers; 14% were probation; and, 8%, other sanctions. Imprisonment was generally from two to six months.[129]

---

127 Boekhout van Solinge, *op. cit.*, page 138.

128 United Nations Office for Drug Control and Crime Prevention, *op. cit.*, page 9.

129 National Report 2001, page 27.

SWITZERLAND[130]

Switzerland's drug policy has attracted considerable attention in recent years. As a result of widely distributed pictures of the open drug scene in Zurich, the country's injection clinics and heroin prescriptions for drug "addicts" are now known around the world. More recently, Switzerland's Parliament introduced a bill to regulate the production and sale of cannabis, and that bill is currently under study.

Switzerland is a Confederation[131] consisting of 26 cantons and half-cantons and has a population of slightly more than seven million inhabitants. The cantons are currently subdivided into 2,904 political communes. The federal Constitution, which was passed in 1848, is the legal basis of the federal state. It guarantees the fundamental rights of individuals and the people's participation in the country's political life, divides jurisdictions between the Confederation and the cantons and defines the powers of the federal authorities. Switzerland is made up of various linguistic, ethnic and denominational communities. Under Article 4 of the Constitution, German, French, Italian and Romansch are the country's four national languages. German is the language spoken by the majority of Swiss (63.7 per cent). All the cantons have their own constitution, parliament, government and courts. The cantons have certain legislative powers which have been conferred on them by the federal Constitution.

Switzerland's political structure is important to our understanding of that country's drug policy. In fact, some writers[132] argue that there are in fact 26 drugs policies in Switzerland, one for each canton and half-canton. This diversity is often overlooked, since the media and drug literature have focused in particular on the "open drug scenes" in Zurich and on the medical prescription of heroin for severally dependent persons, a practice endorsed by the Swiss Confederation.[133]

A harm reduction policy

The recent history of Switzerland's drug policy began towards the end of the 1960s with the increase in psychoactive drug use. As a result, the cantons developed a first drug policy, which was based on three pillars, namely:

- the repression of drug use and trafficking;
- prevention measures aimed at young people;

[130] This section draws to a large degree on the report prepared for the Committee by the Library of Parliament: C. Collin, (2002) *National Drug Policy: Switzerland.* Ottawa: Library of Parliament, report prepared for the Senate Special Committee on Illegal Drugs, available online at www.parl.gc.ca/illegaldrugs.asp.

[131] This term is used to designate the federal state.

[132] Yan Boggio *et al.*, (1997) *Apprendre à gérer : La politique suisse en matière de drogue*, Geneva: Georg, 1997.

[133] *Ibid.*, page 38.

- treatment based on abstinence, which at the time already included methadone programs.[134]

At the beginning of the 1980s, the HIV-AIDS epidemic hit many countries, including Switzerland. There were "open drug scenes" in several Swiss cities, such as Zurich, Bern, Olten and Solothurn. As a consequence, the miserable state of drug dependent persons was becoming increasingly visible contributing to growing concern over the situation. Public and social services were created to help the "addicts" and protect them against HIV and AIDS. Needle exchange programs were set up and "addicts" were encouraged to be vaccinated against hepatitis. The Swiss Federal Office of Public Health (SFOPH) supported many of these services and still does so today, arguing that they help prevent the spread of AIDS. However, the main pillars of Switzerland's official drug policy remained prevention, treatment and law enforcement.

In the 1990s, Switzerland introduced new measures to reduce the problems associated with drug use and adopted a new national drug strategy. The new strategy introduced another pillar, namely harm reduction, which led to the creation of a four-pillar approach. The role of the Confederation in the area of drug policy becomes more defined and aims to support the efforts made by cantons, cities and communes and by private organizations by providing them with reference material, scientific data and training for professionals.

On February 20, 1991, the Swiss government adopted a program of federal measures to reduce the problems related to drug use,[135] currently known as "ProMeDro,"[136] and which was based on the concept of harm reduction. The objectives of the program were as follows:

- to decrease the number of new drug users and to prevent people from becoming drug dependent;
- to help users overcome their addiction (through treatment and social reintegration);
- to improve the living conditions and the health of drug users, to reduce harm and to maintain their social integration.[137]

---

134 Swiss Federal Office of Public Health, *The Swiss Drug Policy*, September 2000, available online at http://www.bag.admin.ch/sucht/f/index.htm.

135 Swiss Federal Office of Public Health, *Mesures fédérales pour réduire les problèmes de la drogue*, Basic document of the Federal Office of Public Health, decision of the Federal Council of February 20, 1991, Doc. no. 3.4.1f.

136 The acronym "MaPaDro" was used to refer to the program of federal measures for the period 1990-1996. The acronym "ProMeDro" is used to refer to the program of federal measures for the period 1997-2002. To avoid confusion, "ProMeDro" is used throughout.

137 Swiss Federal Office of Public Health, *Programme de mesures de santé publique de la Confédération en vue de réduire les problèmes de drogue (ProMeDro) 1998-2002*, October 1998.

To achieve these goals, the following measures were introduced:

- primary and secondary prevention measures aimed at young people and awareness campaigns to prevent them from experimenting with drugs;
- patient management and treatment to help users overcome their addiction;
- harm reduction, AIDS prevention and social reintegration measures to help addicts cope with their dependency in the best possible health conditions and to ensure that the door to a drug-free life remains open;
- ongoing training and development programs for professionals (including those working in the areas of sentencing, programs and social services, as well as hospital workers, pharmacists and family doctors) and for people acting as mediators (such as teachers, youth group facilitators, business personnel and parents);
- the development, co-ordination and regular publication of scientific research on drugs;
- the evaluation of projects and measures in the fields of prevention, patient management and treatment to help identify any gaps or shortcomings, but also to pinpoint and highlight any progress achieved;
- the development of new documentation and information services normally provided by the Swiss Confederation; and
- the co-ordination of measures adopted by the Confederation.

These measures mark the beginning of Switzerland's drug policy, based on a four-pillar approach: prevention, law enforcement, treatment and harm reduction. Between 1991 and 1999, the SFOPH initiated and/or supported approximately 300 projects and programs under the "ProMeDro" initiative at the cost of 15 million francs per year.

Among other activities, the Federal Council asked for a study on heroin-assisted treatment for severely dependent heroin addicts who had failed at other treatment programs. In 1992, the Council passed an order authorizing clinical trials with the medical prescription of heroin, along with a strict scientific evaluation of the trials. The trials began in 1994 and ended on December 31, 1996. The final evaluation report was published in July 1997 and concluded that:

- heroin-assisted treatment for severely dependent heroin addicts improved their physical and/or psychic health, as well as their quality of life (in terms of housing, work and other areas);
- participants' illegal use of heroin and cocaine decreased;
- the users involved in the program committed fewer crimes (the incidence of theft and property and drug trafficking offences fell sharply).[138]

---

[138] M.F. Aebi, Martin Killias and Denis Ribeau, "Prescription médicale de stupéfiants et délinquance : Résultats des essais suisses", *Criminologie*, Vol. 32, no. 2, 1999, page 127-148; see also the testimony of

The Federal Council followed the report's recommendations, and on March 8, 1999, passed the *Ordinance governing the medical prescription of heroin* authorizing heroin assisted treatment, setting objectives, eligibility criteria, administrative measures and providing for such treatment.

Over the same period in 1993 and 1994, two people's initiatives were presented with opposite objectives. The first initiative called for a strict, abstinence-oriented drug policy ("Youth Without Drugs"),[139] and the second proposed the legalization of drug use ("DroLeg").[140] The federal government and Parliament found both initiatives too extreme and recommended their rejection. On September 28, 1997, Swiss voters rejected the initiative "Youth Without Drugs" by a majority of over 70%. On November 29, 1998, Swiss voters rejected the "DroLeg" initiative with a majority of over 74%. By rejecting both initiatives, the Swiss population showed its massive support for the Confederation's more measured approach to drug policy.

Between the time that these popular initiatives were launched and subsequently voted down, some major events influenced the evolution of Swiss drug policy. In 1994, the violence occurring on the "open drug scenes," from Letten to Zurich, made headlines in the international media. Certain government parties (Socialist, Christian Democrat and Radical) clamoured for decriminalization of drug use, increased access to heroin-assisted treatment, stronger prevention measures and stiffer sentences for drug traffickers.[141] The open drug scene in Zurich was shut down in 1995,[142] resulting in new co-operation between the Federal Council, canton representatives and the city of Zurich. A joint task force, called the Drug Delegation, was established. This unusual co-operation made it possible to implement measures that would never have got off the ground under more traditional circumstances: the creation of prison spaces in Zurich for drug traffickers, the adoption of emergency federal measures allowing for more drug addicts to participate in heroin-assisted treatment and the creation of centres for the treatment of hard core users.[143] Today the "open drug scenes" are a thing of the past.

Finally, in October 1998, the program of federal measures to reduce the problems related to drug use (ProMeDro) was renewed for a four-year period. The Confederation set a budget of 18 million francs per year to run this program and staffed it with 15

Professor Ambros Uchtenhagen, Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, February 4, 2002, Issue 13.

139 For more information on this initiative, see the Youth Without Drugs Web site at http://www.jod.ch/f_fr_index.htm.

140 For more information on this initiative, see the DroLeg Web site at www.droleg.ch.

141 Swiss Federal Office of Public Health (2000), *op. cit.*, page 10.

142 See the testimony of the Chief of the Zurich Criminal Police, Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, February 4, 2002, Issue 13.

143 Boggio *et al.*, 1997, *op. cit.*, page 75-80.

positions from the Federal Office of Public Health.[144] The main priorities for ProMeDro from 1998 to 2002 are as follows:

- to strengthen the Confederation's commitment to primary and secondary prevention and early intervention to prevent addiction;
- to consolidate the range of treatments in a co-ordinated system, thereby increasing the likelihood that addiction can be overcome;
- to consolidate harm reduction and social integration measures;
- to establish and operate effectively a national epidemiological monitoring centre based on the focal points REITOX model of the European Monitoring Centre for Drugs and Drug Addiction;[145]
- to forward, in an effective manner, the findings of epidemiological studies, scientific research and evaluations to experts and decision makers;
- to implement a process to foster quality management throughout the entire ProMeDro program, tailored to the needs of the different fields, useful to and used by more than half of the addiction agencies and decision makers concerned (Confederation, cantons, communes, private institutions);
- to ensure optimum co-ordination and organization for various commissions and forums, mainly for the Conference of Canton Delegates on Drug Addiction Problems and the National Drug Liaison Committee.[146], [147]

The Confederation has thus set itself up as a political hub for drug policy and national co-operation

First pillar: prevention

Prevention measures are aimed primarily at achieving three objectives:

- to prevent drug use among individuals, especially children and youth;
- to prevent the problems and harmful effects related to drug use from spilling over onto the individual and society;

---

[144] Federal Office of Public Health (1998), *op. cit.*, page 5.

[145] The EMCDDA coordinates a network of 15 information centres, or national focal points, located in each of the member states. For more information, visit the EMCDDA Web site at http://www.emcdda.org/mlp/ms_fr-4.shtml.

[146] The Conference of Canton Delegates usually meets four times a year. It coordinates drug addiction measures, establishes an annual program and priority catalogue, ensures the exchange of information, debates and adopts positions and responds to consultations, defines and discusses related issues and provides development sessions. See http://www.infoset.ch/inst/kkbs/f-statuten.html (in French). The National Committee consists of representatives from the cities, cantons and the Confederation. Its role is to provide follow-up on implemented measures and ensure that those measures are harmonized.

[147] Federal Office of Public Health (1998), *op. cit.*, page 6-7.

- to prevent individuals from going from casual drug use to harmful use and addiction, with all of its known consequences.

It should be pointed out that the most notable change in prevention has been a transition from the concept that prevention was a matter of preventing someone from ever trying drugs to today's concept of preventing the health and social problems related to drug use, thereby integrating the person's social network and environment as well.

Second pillar: treatment

In Switzerland, there are many types of in-patient and out-patient treatment available to people suffering from drug addiction. The objectives sought through treatment include:

- breaking drug "addicts" of their habit;
- social reintegration;
- better physical and mental health. [148]

As mentioned earlier, heroin assisted treatment has been a recognized type of therapy in Switzerland since 1999. By the end of 1999, there were already 1,650 treatment spaces reserved for hard-core heroin dependent persons in 16 treatment centres. In addition, during the same period, approximately 50% of opiate addicts (estimated to be 30,000) were being treated with medically prescribed methadone, compared to 728 individuals who were receiving this type of therapy in 1979. Those individuals addicted to one or more drugs also have access to in-patient treatment based on abstinence, to a limited number of spaces in transition centres, specialized withdrawal units or clinics, and treatment institutions, as well as out-patient consultation centres.[149] In March 1999, there were 100 institutions providing in-patient withdrawal and rehabilitation treatment in Switzerland, for a total of 1,750 spaces.[150]

Third pillar: harm reduction

The first so-called "low threshold" coping skills institutions made their appearance in Switzerland in the mid 80s. Their purpose was to reduce the health and social risks and consequences of addiction. First and foremost, these institutions gave drug dependent persons a roof over their heads and were often equipped with cafeterias, showers and laundry facilities. They provided addicts with someone who would listen and talk to them. These facilities have evolved over the past ten years and now incorporate medical support for harm reduction (for example, prevention of AIDS and other infections, needle exchange, out-patient medical care, etc.) and social support

---

[148] *Ibid.*, page16.

[149] *Ibid.*, page 16-17.

[150] Federal Office of Public Health, *The Swiss drug policy: A fourfold approach with special consideration of the medical prescription of narcotics*, 1999, page 7.

(street work, soup kitchens, emergency shelters, low threshold centres, etc.). The Swiss Federal Office of Public Health supports many harm reduction projects as part of ProMeDro. Such projects include:

- needle exchanges for drug addicts and inmates;
- injection sites (a statutory notice makes such sites legal);
- offers of employment and housing;
- support for women who prostitute themselves to buy drugs;
- consultation services for the children of drug-addicted parents.[151]

Furthermore, the cantons, communes and private institutions also provide such programs. In 1995, the SFOPH established a central service to support certain social assistance agencies, particularly those with low thresholds, and to advise the cantons, communes and private institutions on planning and funding harm reduction programs. Drug "addicts" have access to such programs without having to meet any particular prerequisites. The objective of these harm reduction services is to limit as much as possible the negative consequences of addiction so that the "addict" is able to resume a normal existence. In addition, these measures are aimed at safeguarding and even increasing the addict's chances of breaking the drug habit.[152]

Fourth pillar: enforcement

The primary goal of enforcement is to reduce supply and to fight the trafficking of narcotics, the illegal financial transactions related to such trafficking (for example, money laundering) and organized crime. Users are not the number one target of police operations in Switzerland. Enforcement of the federal *Narcotics Act* is, to a large extent, the responsibility of the cantons, although the Confederation does monitor the situation closely and can call for and carry out police investigations into drug trafficking. It should be noted that canton and commune laws on policing differ and sometimes result in varying interventions. Furthermore, the drug milieu changes quickly and the methods used to fight drug-related problems are improving and adapting to this milieu.[153] These methods include:

- focussing enforcement activities on the manufacturing of drugs, trafficking and money laundering;
- assigning more officers to the "drug police" and making greater use of specialists from other sectors (finance professionals);
- intercantonal and international cooperation (agreements with police forces from neighbouring countries);

[151] Boggio *et al.*, 1997, *op. cit.*, page 19.
[152] *Ibid.*, page 18-19.
[153] *Ibid.*, page 20-21.

- accelerating and improving the processing of information (networking systems and access to the police department networks from many European countries);
- improving cooperation between the police and the private sector (banks, chemical industries, etc.);
- improving police effectiveness and making greater use of front-line liaison workers;
- strengthening the legal structure (for example, policing legislation, witness protection).[154]

The legal framework

Narcotics legislation in Switzerland has, as is the case in many other countries, been closely tied to the evolution of international conventions. For instance, the 1924 *Narcotics Act* was implemented to enable Switzerland to fulfil the commitments it had made by signing the International Opium Convention of 1912. This law prohibited certain narcotics such as opium, coca leaves, morphine, heroin, cocaine and their derivatives. As a result of Switzerland's signing other conventions and of experience gained from enforcing the 1924 *Act*, the federal *Narcotics Act* was totally revamped and a new law adopted on October 3, 1951. This legislation prohibited the growing, manufacture, sale, distribution and possession of opiates, coca derivatives and cannabis. The purpose of the *Act* was, on the one hand, to regulate the use of narcotics for medical purposes and, on the other hand, to fight against both the abuse and illicit trafficking of narcotics. The *Act* was amended slightly in 1970 when Switzerland signed the Single Convention on Narcotic Drugs of 1961.

Indeed, up until the 1960s, the *Act* was primarily a response to Switzerland's commitments under international conventions because narcotic use was relatively marginal and there was not any real narcotics abuse problem per se to warrant specialized legislation. Moreover, the Federal Council had recognized as early as 1951 that drug addiction was a serious pathology that should not be prosecuted as a crime or an offence. When drug-related problems emerged in the early 1970s, the *Act* was revised in 1975 to provide for medico-social and assistance measures for drug addicts, differentiated punishment for drug use and tougher criminal provisions for illegal drug trafficking.[155]

Following Switzerland's accession to the 1971 UN Convention on Psychotropic Substances, the 1972 amendment to the Single Convention and the adoption of the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (Switzerland has not yet ratified this convention), the *Narcotics Act* was revised in 1996 to provide for the control of narcotic raw materials. Since then, dependence-producing

[154] *Ibid.*, page 21.

[155] Swiss Federal Council, *Message concernant la révision de la loi sur les stupéfiants*, March 9, 2001.

substances and preparations with morphine-, cocaine- or cannabis-like effects have been considered narcotics under this legislation (*Narcotics Act*, s. 1).[156] The list of substances is currently compiled by the Swiss Agency for Therapeutic Products.[157]

With respect to the production, distribution, acquisition and use of narcotics, the current legislation provides that narcotics and psychotropic substances cannot be cultivated, manufactured, prepared or sold without cantonal authorization, in accordance with conditions set by the Federal Council (*Narcotics Act*, s. 4). In addition, a special permit from the Federal Office of Public Health is required for the importation or exportation of controlled narcotics (*Narcotics Act*, s. 5). Furthermore, under section 8 of the *Narcotics Act*, the following narcotics cannot be cultivated, imported, manufactured or sold: smoking opium, heroin, hallucinogens (such as LSD) and hemp for the extraction of narcotics or hash. Section 8 also sets out the conditions governing the treatment of addicts with medical prescription of certain narcotics.

The current legislation also contains criminal provisions that apply to: anyone who unlawfully cultivates, manufactures, extracts, processes or prepares narcotics; anyone who, unless authorized, stores, ships, transports, imports, exports, provides, distributes, sells, etc., or buys, holds, possesses or otherwise acquires narcotics; and anyone who finances illicit traffic in narcotics, acts as an intermediary or encourages consumption (*Narcotics Act*, s. 19). Section 19 offenders are liable to imprisonment or a fine depending on the seriousness, according to the *Narcotics Act*, of the act committed. The intentional consumption of narcotics or the commission of a section 19 offence for personal use is punishable by detention or a fine (*Narcotics Act*, s. 19a). For petty offences, the appropriate authority may stay the proceedings or waive punishment and may issue a reprimand (*Narcotics Act*, s. 19a(2)). However, preparing narcotics for personal use or for shared use with others at no charge is not punishable where the quantities involved are minimal (*Narcotics Act*, s. 19b). Finally, anyone who persuades or attempts to persuade someone to use narcotics is also punishable by detention or a fine (*Narcotics Act*, s. 19c).

A bill to decriminalize cannabis[158]

The Swiss Federal Council recently submitted a major bill to Parliament, the cantons and the public for a fundamental revision of the *Narcotics Act*. That bill, which is set to go through the various stages of canton and national consultation, is based on the observation, similar to our own findings, that:

---

156 *Loi fédérale sur les stupéfiants et les substances psychotropes*, October 3, 1951 (as of November 27, 2001) available on line at http://www.admin.ch/ch/f/rs/812_121/index.html#fn1.

157 New name of the therapeutic products agency, in effect since January 1, 2002.

158 See testimony of Ms. Diane Steber Büchli, Swiss Federal Office of Public Health, before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, February 4, 2002, Issue 13.

> *(...) with regard to cannabis, the gap is too great between the actual situation, the statutory provisions and their implementation. As the Federal Commission on Drug Issues states in its report on cannabis, the prohibitionist system does not prevent cannabis use and cannabis users no longer tend to consider themselves drug users. The risks that cannabis represents for public health must be assessed differently from the way the legislator did it in 1975.*
> *At the time, cannabis was considered a gateway drug. It was felt that the pharmacological properties of cannabis led young cannabis users to opiate or amphetamine use. That view was refuted with the 1989 report of the Sub-commission of the Federal Commission on Narcotics.*
> *The most recent research supports current findings that the effects of cannabis are less hazardous to health than the effects of alcoholism or tobacco abuse. (...)*
> *(...)*
> *The number of users of cannabis derivatives has increased. In 1992, according to the Swiss Health Survey of the Federal Statistics Office, 16.3 per cent of young Swiss citizens aged 15 to 35 said they had previously used hash at least once in their lives. In 1997, 26.7 per cent gave the same answer. All OECD countries have observed the same trend. In the United States, for example, the life prevalence of cannabis use in individuals 18 years of age increased from 32.6 per cent in 1992 to 49.6 per cent in 1997.* [159]

The cannabis revision bill is also based on the observation, **in which we wholeheartedly concur**, that "*the available scientific literature establishes no relationship between severity of legislation and life prevalence of cannabis use.*"[160] It further emphasizes that:

> *The weaknesses of the present act are apparent when it comes to fighting the cultivation of hemp used to produce narcotics and the production and sale of cannabis-based products. Enforcing the act in this area is a highly heterogeneous and costly enterprise; the result is a large market that is very difficult to control and has expanded beyond our borders. Moreover, the need to revise statutory provisions in this area is virtually undisputed.* [161]

The purpose of the revision of the act is thus, in particular, to:

- adapt the Act to the actual situation;
- decriminalize cannabis use and acts leading thereto;
- reinforce youth protection;
- regulate the cultivation, manufacture and trafficking of cannabis;
- restrict the obligation to prosecute;
- reinforce repression in certain areas in a targeted manner.[162]

More specifically, the bill would provide (art. 19c) for the decriminalization of the use of cannabis-related products. In addition, preparatory acts to personal use of cannabis-related products would be decriminalized if committed without affording a

[159] Swiss Federal Council, *Message concernant la révision de la loi sur les stupéfiants*, 2001, page 3554-3555.
[160] *Ibid.*, page 3560. We further discuss this issue in Chapter 21.
[161] *Ibid.*, page 3540.
[162] *Ibid.*, page 3556.

third party the opportunity to use drugs. While the bill does not set out specific limits on quantity–as it would be left to the courts to determine whether it was related to personal consumption - the government publication explaining the bill mentions that as a principle, it does related to personal consumption if the quantity does not exceed what is needed for weekly use. In general, this would mean quantities of 30 grams for possession and 10 average-size plants for cultivation. The publication states that these quantities would vary depending on the person, the way it is consumed, etc.[163]

Article 19d would confer on the Federal Council the power – and not the obligation – to determine priorities in criminal prosecutions. Under this power, the Federal Council could, after consultations with the cantons, set out the conditions under which the prosecution and criminalization of certain offences would be waived, if they are conducted under the legal framework discussed in the next paragraph.[164]

If the Federal Council uses its power under article 19d, article 19f sets out conditions under which the cultivation, production and distribution of cannabis and its derivatives would be allowed. Distribution would not be prosecuted under certain conditions: selling to persons under 18 years of age would not be permitted; the product must not represent a significant risk to health; public order must not be disturbed, advertising would be prohibited, etc. Producers must also submit to a set of strict rules: they may produce solely for point of sale located in Switzerland, notify authorities regarding all crops (species, cultivation area, location, etc.), and specify THC levels. The Federal Council can establish a series of rules such as size and lay out of cultivation areas, the number of distribution centres, etc. In addition, cantons would be able to set out more restrictive rules, particularly with respect to cultivated areas and distribution centres.[165]

The Council did request legal opinions on whether its proposals satisfied the three international conventions.[166] The two opinions concurred that the decriminilization of personal use and related acts would not contravene international conventions. In addition, the waiver of prosecution (or limitation of criminal prosecution) for cultivation, production and distribution would also be consistent with the three conventions. The Federal Council concludes in its *Message* that:

> *In their essential points, the two legal opinions come to the same conclusions. The only difference is in the matter of whether, in cases where a waiver of criminal prosecution in matters pertaining to the cultivation of cannabis and the manufacture and distribution of cannabis products would be introduced, the provisions are sufficient or whether they should be supplemented by a licensing system.*

---

[163] *Ibid.*, pp. 3596-3597.

[164] *Ibid.*, p. 3598.

[165] *Ibid.*, p. 3600.

[166] The findings of one of the experts consulted are presented in Chapter 19 above.

It should be noted on this point that the Netherlands also has a partial limitation on the obligation to prosecute in the areas referred to and that it has not introduced a licensing system. Nevertheless, the principle of the Dutch system has never been disputed as being inconsistent with the UN conventions.[167]

Administration of Swiss drug policy

The Confederation is the hub of Swiss drug policy and co-ordination and harmonization of the various policies and measures put in place by cantons, cities, local authorities and private institutions. Under section 15c of the *Narcotics Act*, the Confederation is responsible for the following tasks [translation]:

- Through grants or other measures, the Confederation shall encourage scientific research on the effects of narcotics, the causes and consequences of narcotics abuse and ways to combat that abuse.
- The Federal Council shall establish the procedures for awarding and calculating grants and shall determine grant amounts.
- The Confederation shall assist cantons and private organizations in the administration of the *Act*. The Confederation shall, *inter alia*, set up a documentation, information and co-ordination office and encourage the training of staff specialized in the treatment of addicts?. The Federal Council shall establish the relevant procedures.

Under section 15a of the *Narcotics Act*, the cantons are responsible for the following tasks [translation]:

- To prevent narcotics abuse, the cantons shall promote information and consultation and set up the institutions needed to do so.
- The cantons shall provide for the protection of those in need of medical treatment or other assistance on account of narcotics abuse and shall assist their return to work and society.
- The appropriate authorities may delegate certain tasks and responsibilities to private organizations.
- The cantons may prohibit the acquisition of narcotics. They shall give notice of their decisions to the Federal Office of Public Health, which shall relay those decisions to health officials in the other cantons for the information of physicians and pharmacists.
- Prescribing, dispensing and administering narcotics for the treatment of addicts shall be subject to special cantonal authorization.

167 Federal Council, *ibid.*, page 3621.

- Where, owing to addiction, a person might constitute a danger to traffic circulation, the service with knowledge of that danger shall advise the appropriate authority.

In principle, the administration of the *Narcotics Act* falls under cantonal jurisdiction, as the cantons have authority for criminal procedure. There are usually a number of stages in cantonal criminal proceedings: police investigation, preliminary hearing, dismissal or referral to court and court decision. In minor cases punishable by fine or detention–and this is the case for a number of offences under the *Narcotics Act*–a penalty can be imposed by an administrative authority (for example, a prefect). The subject, however, is entitled to object and be tried by a court, usually a police court composed of a single, legally trained judge. Cases of moderate seriousness are usually tried by a district court (correctional court) over which a legally trained judge presides, assisted by lay judges. Finally, the most serious offences are heard by assize courts made up of at least one legally trained presiding judge and a jury of citizens. However, because this type of procedure is lengthy, elaborate and costly, most cantons tend to replace assize courts with either district courts or a higher court made up of permanent judges (criminal court).[168]

The Confederation also plays a role in combating drug trafficking; under section 29 of the *Narcotics Act*, the Federal Office of Police (FOP) is the central Swiss agency responsible for controlling illicit traffic in narcotics. The FOP gathers information for the prevention of offences under the *Act* and to facilitate the prosecution of offenders. In order to do so, the Office maintains contact with other federal government agencies involved (Office of Public Health, Customs Administration, the Swiss Post Office administration, cantonal police authorities, central agencies in other countries and the International Criminal Police Organization (Interpol)). To its cantonal and international partners, the FOP is a focal point for information, co-ordination and analysis in the area of Swiss internal security.[169] Since 1996, after a trial period, the Office has operated a drug database called DOSIS. This database is an invaluable tool for the cantons. Cantonal narcotics squads are connected to the system and have direct access to DOSIS because they are required, as is the FOP, to enter information into the database. This system thus promotes co-operation between the FOP and cantonal police authorities. Only information on the illicit narcotics trade is entered into the system; information on those who only use drugs is excluded.[170]

---

[168] Federal Court, *L'organisation judiciaire en Suisse*, available online in French at: http://www.bger.ch/index.cfm?language=french&area=Federal&theme=system&page=content&maskid=195

[169] Federal Office of Police, *Un aperçu de l'OFP*, available online in French at http://www.bap.admin.ch/f/index.htm.

[170] Federal Office of Police, *Exploitation définitive de la banque de données en matière de drogue DOSIS*, June 26, 1996, available online in French at http://www.bap.admin.ch/f/index.htm.

Statistics on narcotics use and offences under the Narcotics Act

This section summarizes parts of a Federal Office of Police publication entitled *Situation Suisse: Rapport de Situation 2000* [2000 Situation Report on Switzerland],[171] prepared by the Analysis and Prevention Service as an interim document, given that a comprehensive report is to be published in 2002. It should be noted that the statistics in the report are distorted by methodological deficiencies. Switzerland is a federal state with 26 cantonal entities (cantons and half-cantons) and offences are not recorded based on the same criteria in every canton. Furthermore, the statistics do not make it possible to control double or multiple entries; some suspects may appear repeatedly in the same year or in different cantons. Finally, only some of the criminal acts under the criminal code are taken into account.[172]

Use

The report found the following trends in 2000:

- a sharp rise in marijuana use;
- a sharp rise in cocaine use;
- a sharp rise in multiple addictions (use of various kinds of narcotics);
- a sharp rise in synthetic drug use (amphetamines and methamphetamines) – Thai pills[173] have become the "in" drug;
- a downward trend in injection heroin use;
- virtually no open drug scenes in Swiss cities;
- 205 deaths due to drugs and recorded by the police (as compared to 405 in 1991) – those over 27 were the most affected age group, for men and for women, and Zurich and Bern were the most affected cantons, with 50 and 36 deaths due to drugs, respectively;
- 18- to 24-year-olds remain the most frequent users of marijuana, hash and hallucinogens, while those over 30 are the most frequent users of cocaine and heroin.[174]

---

[171] Federal Office of Police, *Situation Suisse : Rapport de situation 2000*, Analysis and Prevention Service, 2001, available online in French at http://www.bap.admin.ch/f/index.htm.

[172] *Ibid.*, page 7.

[173] According to the Federal Office of Police press release, Thai pills contain metamphetamine, and their structure closely resembles that of ecstasy. They come from Thailand, where they go by the name of "Yaba" (drug that makes you go crazy). The tablets bear the letters "WY" and smell like vanilla. The substance is usually smoked, using a sheet of aluminium, or absorbed. The risk of addiction among people absorbing the product by smoking it is at least three times greater than among ecstasy users. This drug is a powerful stimulant with effects comparable to those of crack, but longer lasting. These pills may result in irreparable physical and mental damage (loss of memory, depression). They may also cause paranoid hallucinations and violent fits and create psychological dependence faster than ecstasy.

[174] Federal Office of Public Health, 2000, *op. cit.*, page 17-37.

Offences

Federal *Narcotics Act* drug-related offences reported cases rose from 44,307 in 1999 to 46,558 in 2000. This represents a significant increase over the 18,800 reported cases in 1990. A comparison of the number of reported cases per offence type in 1997 and 2000 reveals a downward trend in drug trafficking, smuggling, dual offences and an overall increase – with the exception of 1999[175] – in drug use cases.

The number of reported cases of drug dealing in 2000 fell to 3,021 from 3,711 in 1999. This represented a drop of 18.5%. However, some cantons posted a major hike in reported cases. A case in point was the city of Basel, which recorded an increase of 31%. The report urges caution in interpreting these figures, suggesting that the major drop in the number of reported cases is not in fact due to an improved situation in these specific cantons, but rather to a decrease in the number of cases reported by the police as investigation capacity and officers are deployed in other areas. It should be noted that of a total of 3,021 drug trafficking cases, 78% involved foreigners and 22% Swiss citizens. With respect to the sex of offenders, 82% were men and 7% were women. The sex of the remaining 11% was unknown. The largest percentage (45%) of male offenders were aged between 18 and 24, whereas the majority of female offenders were over 30 (56%), followed by the 18-to-24 age group (27%).[176]

[175] *Ibid.*, page 18-19.
[176] *Ibid.*, page 20-23.

AUSTRALIA[177]

Cannabis was generally little known or used in Australia before the 1960s. However, the drug legislation that was passed in the majority of states and territories in the late 1800s and early 1900s (mainly because of the large number of Chinese who smoked opium) provided a framework that lent itself well to the prohibition of cannabis. The first Australian measures designed to control cannabis use were part of an act passed in 1928 in the state of Victoria to penalize the unauthorized use of Indian hemp and Indian hemp resin. Similar acts were subsequently passed in the other states of the Commonwealth. Penalties for the cultivation, possession and use of cannabis were generally quite harsh in the 1960s and 1970s.[178]

The incentive to revise the laws on cannabis use in South Australia came from the recommendations made in 1979 in the *Report of the South Australian Royal Commission into the Non-Medical Use of Drugs.*[179] One of those recommendations was that small-scale cannabis use not be considered a criminal offence. In support of that recommendation, the Royal Commission cited a number of overseas states, including 10 American states, where such a measure had yielded good results.

National drug strategy[180]

The National Campaign Against Drug Abuse (1985-1992)

The inception of the National Campaign Against Drug Abuse (NCADA) in 1985 was a watershed in Australian drug policy and introduced a focus on public health and harm minimization. The NCADA emphasized that drug use should be treated primarily as a health issue. The decision was made deliberately to situate the program within the Federal Department of Health rather than the Federal Attorney General's Department, due at least in part to the emergence of HIV/AIDS. But the program from the start involved a strong partnership between the Commonwealth (or federal government), States and Territories. It also intended to foster a partnership between health and law enforcement in a comprehensive strategy involving an integrated approach to licit as well as illicit drugs.

---

177 This section draws to a large degree on the report prepared for the Committee by the Library of Parliament: R. MacKay, (2001) *National Drug Policy: Australia.* Ottawa: Library of Parliament, report prepared for the Senate Special Committee on Illegal Drugs, available online at www.parl.gc.ca/illegaldrugs.asp.

178 For a history of the laws relating to cannabis in Australia, see: McDonald *et al.*, *Legislative Options for Cannabis Use in Australia*, Commonwealth of Australia, 1994, available online at: http://www.druglibrary.org/schaffer/Library/studies/aus/cannabis.htm.

179 South Australian Government, Royal Commission of Inquiry into the Non-Medical Use of Drugs South Australia 1979, *Final Report* (Chairperson: Sackville).

180 For an outline of the National Drug Strategy from 1985 to the present, see: http://www.aic.gov.au/research/drugs/strategy/index.html.

The philosophy of harm minimization includes the strategies of supply, demand and harm reduction. The mission of Australia's drug strategy is to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs.

The National Drug Strategy (1993-1997)

A further principle underlying the new drug strategy was that reliable data, new approaches and evaluation of effort were required. As part of this new effort, the Ministerial Council on Drug Strategy (MCDS) commissioned two independent evaluations of the NCADA to assess progress and make appropriate recommendations. After these two evaluations, one released in 1988 and the other, *No Quick Fix*, in 1992, the campaign was relaunched as the National Drug Strategy (NDS). Incorporating the recommendations from the two evaluations, the National Drug Strategy continued to stress the importance of harm minimization principles. Some of the goals of the Strategy were to:

- Minimize the level of illness, disease, injury and premature death associated with the use of alcohol, tobacco, pharmaceutical and illicit drugs;
- Minimize the level and impact of criminal drug offences and other drug-related crime, violence and antisocial behaviour within the community;
- Minimize the level of personal and social disruption, loss of quality of life, loss of productivity and other economic costs associated with the inappropriate use of alcohol and other drugs; and
- Prevent the spread of hepatitis, HIV/AIDS and other infectious diseases associated with the unsafe injection of illicit drugs.

The strategic plan identified six specific concepts which were to underpin the development and implementation of drug policy: harm minimization; social justice; maintenance of controls over the supply of drugs; an intersectoral approach; international cooperation; and evaluation and accountability.

Overall responsibility for the broad policy direction and operation of the NDS rests with the MCDS, which comprises both health and law enforcement ministers from each State and Territory as well as from the Commonwealth government. The council meets annually. The National Drug Strategy Committee (NDSC) provides administrative support for the MCDS. It is mandated to develop proposals for the NDS, implement the NDS, develop policy proposals relating to licit and illicit drugs and liaise with other governmental agencies on matters relating to the NDS. It consists of one health and one law enforcement representative from each jurisdiction. The MCDS and NDSC develop national policies and directions which individual jurisdictions then implement as appropriate within their social, political and economic environments.

Report on the National Drug Strategy (1997)[181]

In 1997 a report evaluating the National Drug Strategy (1993-1997) was produced. This report, entitled *The National Drug Strategy: Mapping the Future*, lauded the NDS for a unique combination of features which had brought it international attention and acclaim:

- The NDS recognizes the complexity of drug issues and the need to provide front-line health professionals and others dealing with drug problems with a wide range of options based on the concept of harm minimization. These range from abstinence-oriented interventions to programs aimed at ameliorating the consequences of drug use among those who cannot be reasonably expected to stop using drugs at the present time;
- The NDS adopts a comprehensive approach to drugs, which encompasses the misuse of licit as well as illicit drugs. Policies and programs to address the problems of illicit drugs, alcohol, tobacco and pharmaceuticals all fall under the aegis of the NDS;
- The NDS approach to drugs stresses the promotion of partnerships– between health, law enforcement, education, non-overnmental organizations, and private industry; and
- The NDS attempts to address drug issues in a balanced fashion. This refers to the appropriate balance of effort between the Commonwealth, States and Territories, a balance between supply and demand reduction strategies, and a balance between treatment, prevention, research and education.

Contrary to the fears of many that harm minimization policies might lead to increased public acceptance and use of illicit drugs, the evaluation found that there was no discernible trend in the use of drugs such as heroin, amphetamines and cocaine, although there was some increase in marijuana use. The NDS was also found to have contributed to the success of the National HIV/AIDS Strategy in reducing the spread of HIV, Hepatitis C and other infectious diseases among intravenous drug users.

The National Drug Strategic Framework (1998/1999-2002/2003)[182]

The National Drug Strategic Framework maintains the policy principles of the previous phases of the National Drug Strategy and adopts the recommendations of the

---

181 See Eric Single and Timothy Rohl, *The National Drug Strategy: Mapping the Future*, A Report commissioned by the Ministerial Council on Drug Strategy, Canberra, April 1997. Available online at: http://www.health.gov.au/pubhlth/publicat/document/mapping.pdf.

182 Ministerial Council on Drug Strategy, *National Drug Strategic Framework 1998-99 to 2002-03: Building Partnerships*, Prepared for the Ministerial Council by a joint steering committee of the Intergovernmental Committee on Drugs and the Australian National Council on Drugs, Canberra, November 1998. Available online at: http://www.health.gov.au/pubhlth/nds/resources/publist.htm.

report from the previous phase. Its focus remains on harm minimization and continues to seek a balance between supply-reduction, demand-reduction and harm-reduction strategies, emphasizing the need for integration of the various strategies. It also continues the emphasis on evidence-based practice, based on rigorous research and evaluation, including assessment of the cost-effectiveness of interventions.

This next phase of the NDS places emphasis on extending the partnership between health and law-enforcement agencies to take in a broader range of partners, as recommended in the evaluation report. Thus the Intergovernmental Committee on Drugs, which consists of health and law enforcement officers from each Australian jurisdiction, is expanding to include officers from the portfolios of customs and education. The MCDS will now be supported by the Australian National Council on Drugs, consisting of people with relevant expertise from the government, non-government and community-based sectors to provide policy advice. These bodies will develop a series of National Drug Action Plans which will specify priorities for reducing the harm arising from the use of licit and illicit drugs, strategies for taking action on these priorities, and performance indicators.

The National Illicit Drug Strategy (1998 –)[183]

In 1997, the Australian government launched the National Illicit Drug Strategy "Tough on Drugs" as the next major phase of the National Drug Strategy. Its implementation began in 1998. The Strategy encompasses a range of supply reduction and demand reduction measures at a total cost of AUD $516 million. Funding for the Strategy is split between demand-reduction strategies, which are being implemented by the Department of Health and Aged Care and the Department of Education, Training and Youth Affairs, and supply-reduction strategies, which are being implemented by the Attorney-General's Department, the Australian Federal Police and the Australian Customs Service. AUD$213 million has been allocated for a range of supply reduction measures to intercept more illicit drugs at borders and within Australia. Law enforcement efforts include funding for 10 new Federal Police anti-drug mobile strike teams to help dismantle drug syndicates within Australia as well as increased funding for the Australian Customs Service to enhance its capacity to intercept drug shipments.

The remaining AUD$303 million has been allocated for demand reduction initiatives which cover five priority areas:

- Treatment of users of illicit drugs, including identification of best practice,
- Prevention of illicit drug use,
- Training and skills development for front line workers who come into contact with drug users,
- Monitoring and evaluation, including data collection,
- Research.

[183] For further details on the National Illicit Drug Strategy, see the Australian Department of Health and Aged Care Web site: http://www.health.gov.au/pubhlth/strateg/drugs/illicit.

In conjunction with the new strategy, the Intergovernmental Committee on Drugs has been established to provide policy advice for government ministers on a full range of drug-related matters.

In June 1999, Commonwealth, State and Territory health and law enforcement Ministers agreed on a national approach to the development of a drug diversion initiative. This was designed to support the diversion of illicit drug users from the criminal justice system into education and treatment. Diversion involves a graduated series of interventions appropriate to the seriousness of the offence and the circumstances of the offender. Diversion is not considered appropriate for trafficking offences. Drug-involved offenders can be cautioned on the streets and provided with treatment referral information if their offence is possession of a small quantity of drugs. They can be sent for assessment or directly to treatment rather than prison, as long as the offence is not serious and they do not pose a threat to society. Courts and correctional systems can also use commitment or referral to community-based treatment as an adjunct to probation or parole from prison. There is also treatment within correctional facilities and corrections-operated or funded therapeutic communities and halfway houses.[184]

Assessment of the National Drug Strategy (2001)[185]

Based on the concept of harm minimization rather than the need to eliminate drug use, the NDS recognizes the complexity of drug issues and the need to provide front-line health professionals and others dealing with drug problems with a wide range of options. These options range from abstinence-oriented interventions to programs aimed at ameliorating the consequences of drug use among those who cannot reasonably be expected to stop using drugs immediately. The goals, strategies, guiding principles and performance indicators for the NDS are established by a National Drug Strategy Committee. This committee consists of high-level civil servants from health and law enforcement ministries of each state and territory as well as their counterparts from the federal government. This shared decision-making has been seen as a strength of the NDS since it enhances government co-operation and ensures a high level of visibility for the drug strategy.

Professor Eric Single noted that the Australian government had followed up on a number of the recommendations he had made to improve the NDS. For example, the NDS was renewed for five years, funding was increased, a specialized NDS unit was

---

184 For further information, see: Ministerial Council on Drug Strategy, *National Action Plan on Illicit Drugs, 2001 to 2002-03*, Prepared by the National Expert Advisory Committee on Illegal Drugs, Canberra, July 2001. Available online at: http://www.health.gov.au/pubhlth/nds/resources/publist.htm.

185 See testimony of Professor Eric Single before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, May 2001. Available online at: www.parl.gc.ca/drogues-illicites.asp.

created within the Commonwealth Ministry of Health, and action plans were developed with regard to other recommendations.[186]

Legislative framework

Under Australia's federal structure, criminal law– and responsibility for enforcing drug laws–is primarily the responsibility of state governments. Australia has ratified the three major international treaties on illicit drugs, and the obligations under those treaties are effected in three pieces of federal legislation: the *Narcotic Drugs Act 1967*, the *Psychotropic Substances Act 1976* and the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990.*

The drug laws in Australian jurisdictions

The law relating to illicit drugs is made and enforced in Australia on a state and territorial level. It varies markedly between jurisdictions, but its structure is broadly similar. The key legislation from each jurisdiction is as follows:

New South Wales	*Drug Misuse and Trafficking Act 1985*; *Drug Court Act 1998*
Victoria	*Drugs, Poisons and Controlled Substances Act 1981*
Queensland	*Drugs Misuse Act 1986*; *Drug Rehabilitation (Court Diversion) Act 2000*
Western Australia	*Misuse of Drugs Act 1981*
South Australia	*Controlled Substances Act 1984*
Tasmania	*Poisons Act 1971*
Northern Territory	*Drugs of Dependence Act 1990*
Australian Capital Territory	*Drugs of Dependence Act 1989*
Commonwealth	*Customs Act 1901* *Narcotic Drugs Act 1967* *Psychotropic Substances Act 1976* *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990*[187]

[186] *Ibid.*

[187] The illegal drug legislation in effect in the states and territories may be consulted online at: http://www.aic.gov.au/research/drugs/context/legislation.html

Each act creates, in one form or another, the basic offences of possession, use, cultivation, production and trafficking, supplying and selling. The acts also contain lengthy schedules, derived from various international conventions, listing which drugs are prohibited, and defining various amounts, such as "traffickable" and "commercial" quantities. These quantities are used to determine maximum penalties for sentencing purposes.

The typical maximum penalties for the more serious offences, such as trafficking in "commercial quantities," are in the range of 25 years to life, although most jurisdictions apart from Queensland set lower maximums for offences involving cannabis. Most acts provide for persons who have been found guilty of simple possession and/or use offences to receive a term of imprisonment, but it is very uncommon now for this penalty to be imposed. Particularly for the less serious offences, there is often a very substantial gap in sentencing between the "law on the books" and the "law in practice." For example, in Queensland, where the offence of possession carries a notional maximum penalty of 15 years imprisonment and a maximum fine of AUD $300,000, the standard penalty applied in the Magistrates Court – where the overwhelming majority of possession charges are heard – is a fine of a few hundred dollars, often with no conviction being recorded.[188]

Since 1987 in South Australia, 1992 in the Australian Capital Territory, and 1996 in the Northern Territory, people detected committing "minor" cannabis offences have been able to avoid a court appearance altogether by paying a relatively modest "on-the-spot" fine. While cannabis possession is still prohibited, it is sanctioned by a civil, not a criminal, penalty. In addition, Victorian legislation provides for the imposition of pre-conviction bonds for first offenders charged with minor drug offences (*Drugs Poisons and Controlled Substances Act 1981*, s. 76). First offenders are given a bond, and no conviction is recorded if the bond conditions are complied with. But in Victoria, New South Wales, Tasmania, Queensland, and Western Australia all cannabis possession, use and supply is criminally prohibited with criminal penalties being imposed. In addition, in all jurisdictions the penalties imposed for commercial dealing are still very substantial, especially for offences at the upper end of the scale.

In the civil prohibitionist jurisdictions, the offences attracting a civil infringement notice include possession of small amounts of cannabis plant (up to 100g in South Australia, 25g in the Australian Capital Territory, and 50g in the Northern Territory) and cultivation of cannabis plants (up to three in South Australia, five in the Australian Capital Territory, and two in the Northern Territory). Failure to pay the fines may result in court appearances and subsequent conviction.

The criminal prohibitionist jurisdictions have also recently adopted "diversionary" cautioning procedures which allow first or second time cannabis possession/use

[188] For more information on Australian drug laws, see David Brereton, "The History and Politics of Prohibition", in *Drugs and Democracy*, *supra*.

offenders to receive a caution or education/counselling session instead of the normal court appearance.

"Drug Courts" have been established in four Australian jurisdictions – Queensland, New South Wales, South Australia, and Victoria. In Queensland and New South Wales these "diversionary" courts have been established by legislation while in South Australia and Victoria they operate on a less formalized basis.[189]

A notable feature of Australian drug laws is the use of provisions which contravene the long-established principle that the burden of proof in criminal cases should be on the prosecution to prove each element of the offence beyond reasonable doubt. For example, the *Drugs Misuse Act 1986* (Queensland) contains a "deeming provision" for the offence of possession. This means that, if a prohibited drug is found on someone's premises, this will be regarded as conclusive evidence that the drug was in the possession of the occupier, unless he or she can persuade the court that they "neither knew nor had reason to suspect that the drug was in or on that place" (s. 57(c)). Another example is s. 235 of the Commonwealth *Customs Act 1901*. This provision requires a person who has more than a certain quantity of drugs in his or her possession to prove, on the balance of probabilities, that he or she did not intend to engage in commercial dealings in relation to those drugs. If the person cannot prove this, they will be sentenced on the basis that they had an intention to traffic.

Another aspect of Australian drug laws to note is the wide range of powers which are available to police and other law enforcement bodies to detect and investigate drug offences. Under the Queensland *Drugs Misuse Act 1986*, for example, police have had the power in relation to any quantity of any illegal drug to: stop, search, seize and remove motor vehicles; detain and search persons; order internal body searches; and enter and search premises with or without a warrant (s. 18). In addition, for offences such as drug trafficking, Queensland police are empowered to apply to a court to have listening devices installed on private premises.

For law enforcement bodies operating at the federal level, and in most states other than Queensland, telecommunications interception powers are also available for the investigation of serious drug offences under the Commonwealth *Telecommunications (Interception) Act 1979*.

Over the last decade, most jurisdictions have also passed confiscation of profits legislation which can be used to attack the assets of drug traffickers and producers. In most cases this action can be taken only after the person has been convicted, but in New South Wales a confiscation order can be made without requiring a conviction, where the Supreme Court is satisfied that "it is more probable than not" that the person has engaged in drug-related activities (*Criminal Assets Recovery Act 1990*).

---

[189] For further details on Australian drug courts, see: http://www.aic.gov.au/research/drugs/context/courts.html

Decriminilization in Australia[190]

While the National Drug Strategy provides a general framework for responses to drug problems, drug offences and the associated penalties in Australia are a matter of state and territorial jurisdiction. Some Australian states and territories have adopted cannabis decriminilization measures while others have not.

The first Australian jurisdiction to adopt cannabis decriminilization measures was South Australia. The Cannabis Expiation Notice (CEN) scheme came into effect in South Australia on 30 April 1987. Under this scheme, adults coming to the attention of police for "simple cannabis offences" could be issued with an expiation notice. Offenders were able to avoid prosecution by paying the specified fee or fees (ranging from AUD $50 to AUD $150) within 60 days of the issue of the notice. Failure to pay the specified fees within 60 days could lead to prosecution in court, and the possibility of a conviction being recorded. Underlying the CEN scheme is the rationale that a clear distinction should be made between private users of cannabis and those who are involved in dealing, producing or trafficking in cannabis. This distinction was emphasized at the introduction of the CEN scheme by the simultaneous introduction of more severe penalties for offences relating to the manufacture, production, sale or supply of all drugs of dependence and prohibited substances, including offences relating to larger quantities of cannabis.

The CEN scheme was modified by the introduction of the *Expiation of Offences Act, 1996* which now provides those served with an expiation notice the option of choosing to be prosecuted in order to contest being given the notice. Previously those served with a notice had to let the payment of expiation fees lapse in order to secure a court appearance to contest the notice. In choosing to be prosecuted, however, people issued a notice have their alleged offence converted from one which can be expiated to one which still carries the possibility of a criminal conviction.

The Australian Capital Territory (in 1992) and the Northern Territory (in 1996) introduced similar expiation schemes. Victoria implemented a system of cautions for minor cannabis offenders in 1998 and Western Australia has followed with a similar scheme.

In all cases, cannabis possession remains a criminal offence. By their nature, these provisions reduce, as necessary, the prison term in which the possession of small quantities of cannabis for personal use would previously have resulted.[191]

Various evaluation studies since conducted have revealed significant savings and reduced negative social impact on persons convicted of minor cannabis offences. None

---

[190] For further details on this topic, see: Eric Single, Paul Christie and Robert Ali, "The Impact of Cannabis, Decriminilisation in Australia and the United States", *Journal of Public Health Policy*, 21,2, Summer 2000, page 157-186. Available online at: http://www.parl.gc.ca/37/1/parlbus/commbus/senate/Com-f/ille-f/presentation-f/single-f.htm.

[191] For a fuller discussion of the legislative possibilities concerning cannabis, see McDonald *et al.*, *Legislative Options for Cannabis Use in Australia*, *supra*.

of the studies upon levels and patterns of cannabis use in South Australia[192] have found an increase in cannabis use which is attributable to the introduction of the CEN scheme. Cannabis use did increase in South Australia over the period from 1985 to 1995 but this was so throughout Australia, including in jurisdictions with a total prohibition approach to cannabis. In fact, the largest increase in the rate of weekly cannabis use across all Australian jurisdictions occurred in Tasmania, a prohibitionist state.[193]

A comparative study of minor cannabis offenders in South Australia and Western Australia concluded that both the CEN scheme and the more punitive prohibition approach had little deterrent effect upon cannabis users. Offenders from both jurisdictions reported that an expiation notice or conviction had little or no impact upon subsequent cannabis and other drug use. However, the adverse social consequences of a cannabis conviction far outweighed those of receiving an expiation notice. A significantly higher proportion of those apprehended for cannabis use in Western Australia reported problems with employment, further involvement with the criminal justice system, as well as accommodation and relationship problems.[194]

In the law enforcement and criminal justice areas, the number of offences for which cannabis expiation notices were issued in South Australia increased from around 6,000 in 1987/88 to approximately 17,000 in 1993/94 and subsequent years. This appears to reflect the greater ease with which police can process minor cannabis offences and a shift away from the use of police discretion in giving offenders informal cautions to a process of formally recording all minor offences. Substantial numbers of offenders still received convictions due to their failure to pay expiation fees on time. This was due in large part to a poor understanding by cannabis users of the legal consequences of not clearing expiation offences and due to financial difficulties. Most CENs are issued for less than 25g of cannabis and half of all CENs issued were received by people in the 18- to 24- year-old age group.[195]

The scheme has proven to be relatively cost-effective and more cost-effective than prohibition would have been. The total costs associated with the CEN scheme in 1995/96 were estimated to be around AUD $1.24 million while total revenue from fees and fines was estimated to be around AUD $1.68 million. Had a prohibition approach

---

[192] Single, Christie, and Ali, *supra*, Notes 3, 11, 12, 18, 19 and 50. See also Maurice Rickard, *Reforming the Old and Refining the New: A Critical Overview of Australian Approaches to Cannabis*, Department of the Parliamentary Library, Information and Research Services, Research Paper No. 6 2001-02, 2001, page 29. Available online at: http://www.aph.gov.au/library (listed under Research Papers).

[193] Rickard, *op. cit.*, page 30.

[194] National Drug Research Institute, Curtin University of Technology, *The Regulation of Cannabis Possession, Use and Supply*, A discussion document prepared for the Drugs and Crime Prevention Committee of the Parliament of Victoria, Perth, Western Australia, 2000, page xxxiv.

[195] *Ibid.*, page xxxiii.

been in place, it is estimated that the total cost would have been around AUD $2.01 million, with revenue from fines of around $1 million.[196]

A report on the CEN scheme[197] noted that it appeared to have numerous benefits for the community, not the least of which were cost savings for the community as a whole, reduced negative social impacts for offenders, and greater efficiency and ease in having minor cannabis offences dealt with, associated with less negative views of police held by offenders. Yet the rate of expiation of notices has remained low, compared with other types of infringement notices, at around 45%.

Administration

Public costs

In financial terms, Commonwealth and State Government expenditure in response to illicit drugs in 1992 was estimated at AUD $620 million. Of this sum, 84% was allocated to law enforcement, 6% to treatment, and 10% to prevention and research. Commonwealth and state expenditure on methadone programs has been estimated at AUD $30 million per year.

Based on various more recent estimates, it is likely that more than AUD $200 million is spent annually in the health and social welfare sectors by governments as a direct or indirect result of the illicit drugs trade.[198] It is estimated that AUD $450 to AUD $500 million is the annual cost to the criminal justice system incurred by illicit drugs.[199] It is estimated that more than AUD $312 million is raised each year by heroin users/dealers through property crime.[200] Law enforcement estimates suggest that drugs generate at least AUD $2 billion annually within Australia. In addition, it has been suggested that a significant proportion of the estimated AUD $3.5 billion laundered in and through Australia each year can be attributed to illicit drugs.[201]

The economic costs associated with the prevention and treatment of drug-related illness, loss of productivity in the workplace, property crime, theft, accidents and law enforcement activities are over AUD $18 billion annually.[202]

---

196 Rickard, *op. cit.*, page 33.

197 Robert Ali *et al.*, *The Social Impacts of the Cannabis Expiation Notice Scheme in South Australia*, Department of Health and Aged Care, Canberra, May 1998. Available online at: http://www.health.gov.au/pubhlth/publicat/drugs.htm.

198 John Broome, "Impacts Upon Social and Political Life", in *Drugs and Democracy*, *op. cit.*, page 117.

199 *Ibid.*, page 117. See also: Adam Sutton and Stephen James, "Law Enforcement and Accountability", in *Drugs and Democracy*, *op. cit.*, page 163, where an estimate of AUD $404 million is given for the annual cost to the Commonwealth, States and Territories of enforcing laws against illicit drugs.

200 Broome, *supra*, page 117.

201 *Ibid.*, page 118.

202 This figure includes costs associated with the use of alcohol and tobacco. See Timothy Rohl, "Evaluating the National Drug Strategy", in *Drugs and Democracy*, *supra*, page 134.

Social costs

In a study of the social impacts of a conviction for a minor cannabis offence on first time offenders, a significant minority of the sample was shown to develop less favourable attitudes towards police, and there was evidence that many respondents had experienced adverse consequences in terms of employment difficulties, further problems with the law, and problems in relationships and accommodation.[203]

A cost of making cannabis illegal is the exposure of cannabis buyers to a range of other potentially more harmful illicit drugs which are available for sale. Another cost is the involvement of organized crime in large scale cannabis production and distribution in Australia. Finally, the illicit drug market generates a sizeable cash economy. It is not too surprising that some police officers become involved in corrupt activities such as drug use, drug dealing, protection of drug dealers, theft of drugs and/or money, and the presentation of false evidence in court.[204]

Statistics

Use[205]

The Australian Institute of Health and Welfare conducts a National Drug Strategy Household Survey (NDSHS) every 2-3 years. This survey has been conducted since 1985 with the seventh survey taking place in 2001. The last survey for which results are available took place in 1998.[206] 10,300 Australians aged 14 years and older participated in the NDSHS. Respondents were asked about their knowledge of drugs, their attitudes towards drugs, their drug consumption histories, and related behaviours.

The results from the NDSHS in 1998 indicate that approximately 46% of the Australian population had used an illicit drug at some time, while 23% of Australians reported using any illicit drug in the twelve months preceding the survey. Marijuana was the most common illicit drug used, with 39.1% of those aged 14 years and over having used the drug at some time in their lives and 17.9% having used it recently. Of those who had used marijuana, almost half had used it in the past 12 months. The prevalence of lifetime use of pain-killers/analgesics (for non-medical purposes) was 11.5%, followed by hallucinogens (9.9%) and amphetamines (8.8%). Only 2.2% of the Australian population had ever used heroin, with 0.8% reporting recent usage. The

---

203 The Regulation of Cannabis Possession, Use and Supply, *supra*, page 40.

204 *Ibid.*, page 40-43.

205 Megge Miller, and Glenn Draper, *Statistics on Drug Use in Australia 2000*, Australian Institute of Health and Welfare, Canberra, May 2001. Available online at: http://www.aihw.gov.au/publications/phe/sdua00/index.html.

206 For detailed results of the 1998 NDSHS, see: Pramod Adhikari and Amber Summerill, *1998 National Drug Strategy Household Survey: Detailed Findings*, Australian Institute of Health and Welfare (Drug Statistics Series No. 6), Canberra, October 2000. Available online at: http://www.aihw.gov.au/publications/health/ndshs98d/index.html.

prevalence of cocaine use was slightly higher, with lifetime use in 4.3% of the respondents and recent use in 1.4%.

The second national survey on the use of over-the-counter and illicit substances by secondary students was conducted in 1999. The survey collected data from 25,480 students aged 12-17 years from 434 secondary schools throughout Australia. According to the survey, substance use increased with age for all substances except for inhalants and steroids. Across all ages, the most common substances used were analgesics (for medical and non-medical purposes), with at least 95% of those surveyed reporting the use of this substance. Marijuana use was also relatively high, particularly among those aged 16-17 years, who were more likely than the general community to use marijuana (47% versus 39%). Overall, a similar number of male and female students had tried the substances surveyed. However, slightly more males (32%) than females (29%) had used marijuana, while slightly more females than males had used analgesics for any purpose (98% versus 96%). Apart from these two substances, lifetime and recent illicit substance use was similar for both males and females.

Offences[207]

Marijuana/cannabis is consistently the most common drug for which people are arrested in Australia, accounting for 70% of all illicit drug arrests in 1998-99. However, the number of persons arrested for either the possession or supply of marijuana has fallen sharply from almost 79,000 in 1995-96 to approximately 58,000 in 1998-99.

The most common drug-related offence for which people were imprisoned was dealing/trafficking in drugs. Of the 1,663 people in prison in 1999 for drug-related offences, 78% were imprisoned for dealing/trafficking offences, with a further 11% imprisoned for possession/use of illicit drugs. The proportion of the total prison population imprisoned for drug-related offences has steadily declined, from 11% in 1995 to 9% in 1999. The proportion of people imprisoned for possession/use of drugs has remained stable over the past five years at 1%, while the proportion of those in prison for dealing/trafficking drugs and manufacturing/growing drugs is steadily decreasing.

Attitudes to drug use and drug legalization

The regular use of illicit drugs was not considered to be acceptable among the vast majority of the respondents in the 1998 NDSHS. Males were more likely to accept regular illicit drug use than were females. Marijuana was the most widely accepted illicit drug, with 30.5% of males and 20.6% of females supporting regular use.

Support for the legalization of illicit drugs follows a similar pattern to that of the acceptability of regular illicit drug use. The legalization of marijuana was supported by 33.8% of males and 25.1% of females. By contrast, support for the legalization of heroin, amphetamines and cocaine was less popular. Only 7% of males and 5.1% of

[207] Miller and Draper, *supra*, page 53-58.

females supported the legalization of cocaine. Those who supported the legalization of heroin, amphetamines and cocaine were generally aged 20-29 and 40-49 years.

THE UNITED STATES[208]

A proper description of the illegal drug policies, and even more so of drug practices, in the United States would in itself be long enough to fill a single report. Consider this: the research budget of the National Institute on Drug Abuse (NIDA) alone amounts to US $1 billion, approximately 80 per cent of funding allocated to illicit drug research worldwide; the budget of the Office for National Drug Control Policy (ONDCP) is more than US $18 billion, compared to that of the Canadian Drug Strategy, which is CDN $16 million, approximately one-half of one per cent of the US office's budget; and total expenses relating to illegal drugs are approximately US $35 billion. Furthermore, given the complexity of the American political system and the diversity of its population, one can only imagine the difficulty of accurately representing US drug policies.

What is more, the United States and illegal drugs are inextricably intertwined. As seen in the last chapter, the USA has played and continues to play a preponderant role in the negotiation and enforcement of international drug conventions. To think of drugs where the United States is involved is automatically to think of the "war on drugs" and the legions of statistics on incarceration, harsh sentences and the enormous economic and social costs that result therefrom.

In this section, we can only scratch the surface of this complex issue. Fortunately, in previous chapters, we have discussed various figures on the United States, use rates in Chapter 6 and research into effects in Chapter 7, for example. Our task was made even more difficult by the fact that we were unable to hear government representatives at the public hearings. In our single day of hearings in the United States, we heard from the Governor of New Mexico, Mr. Gary Johnson, and Mr. Ethan Nadelman of the Lindesmith Centre-Drug Policy Foundation. It was not until June 10 of this year that we were able to have a private meeting with Dr. Hanson, the director of NIDA and, on June 11, an *in camera* session with Mr. Walters, the director of the ONDCP.

The federal-state legislative framework

Historically, most criminal law and its enforcement was a matter under the jurisdiction of the states. Article I of the U.S. Constitution delineates the federal government's areas of legislative authority and the Tenth Amendment expressly provides that all powers not granted to the central government belong to the states. Criminal law is not among the powers specified as being within the federal

[208] This section draws to a large degree on the report prepared for the Committee by the Library of Parliament: B. Dolin, *National Drug Policy: United States*. Ottawa: Library of Parliament, 2002, report prepared for the Senate Special Committee on Illegal Drugs, available online at www.parl.gc.ca/illegaldrugs.asp.

government's purview and in Congress' early days, federal criminal laws were restricted to acts injurious to the national government, such as treason and counterfeiting, or offences of an extra-territorial nature, such as piracy and felonies committed on the high seas.

Despite this, the U.S. Congress has managed to assume a significant role in the criminalization of drug use. Although the "Father of the Constitution," James Madison, had assured the states that their powers were "numerous and indefinite" and those of the central government "few and defined,"[209] judicial constitutional analysis subsequently provided a very wide interpretation of the sphere of congressional authority. Beginning with the 1819 case of *McCulloch v. Marlyland*[210] the U.S. Supreme Court has given a broad reading to the Article I provision that the federal government may enact all laws that are "necessary and proper" for executing its listed powers. Two of Congress' listed powers are taxation and the regulation of foreign and interstate commerce. As discussed below, the federal government has used these heads of power as the foothold for entering into the regulation of drug use.

Historical[211]

From the time of the U.S. Civil War (1861-1865) to the end of the 19th century, the use and sale of opium, morphine, cocaine and other psychoactive drugs were legal and common. Opium was available with or without a prescription and was an ingredient in many patent medicines, including various pain-killers, cough mixtures and teething syrups for infants. Cocaine was also used medicinally, as well as in soft drinks and wine.

Things started to change around the turn of the century. Heroin was first isolated in 1898 and was purported to convey the same benefits as opium or morphine, without the risk of addiction. The realization of heroin's addictive properties soon after its introduction coincided with racist appeals to protect American society from drugs. Initially, two drugs were targeted: Cocaine, associated mainly with Blacks who were said to go on violent rampages under its influence, and opium, the smoking of which was associated with the Chinese. Alcohol temperance societies and religious groups also played key roles in lobbying for prohibition.

Despite strong opposition from the patent medicine industry, the U.S. Congress passed the *Pure Food and Drug Act* in 1906. This legislation required over-the-counter medicines to list the amount of drugs contained in them in the hope that this would

---

[209] In David P. Currie, *The Constitution of the United States: A Primer for the People*, Chicago: University of Chicago Press, page 26.

[210] 17 U.S. 316.

[211] See Steven R. Belenko, ed., *Drugs and Drug Policy in America: A Documentary History*, Westport: Greenwood Press, 2000; Joseph D. McNamara, "Commentary: Criminalization of Drug Use" *Psychiatric Times*, Vol. XVII(9) *Psychiatric Times*; Luna, Erik Grant, "Our Vietnam: The Prohibition Apocalypse", (1997) 46 Depaul L. Rev. 483. Stephen B. Duke, "Commentary: Drug Prohibition: An Unnatural Disaster", (1995) 27 Conn. L. Rev. 571).

reduce the use of such medicines. Soon to follow was the *Opium Smoking Act of 1909 (as Amended, 1914)* in which Congress banned the importation of the drug for non-medicinal purposes.

The *Harrison Narcotic Act* of 1914

The *Harrison Act* was a significant development in American drug policy. Earlier legislation enacted in 1909 had restricted the importation of opium in accordance with the international conventions against the use of the drug. Initially designed to medicalize cocaine and heroin by restricting their distribution to physicians, the *Harrison Act* was passed in 1914. Its stated purpose was soon altered by the influence of the prohibitionist fervour of the day and this legislation became the unusual model upon which the administration of American narcotics policy would develop. Constitutional limits, as perceived at the time, meant that federal laws had to focus on international controls, interstate transfer and taxation. The Act therefore addressed drug use by requiring anyone selling drugs to be licensed and to keep records of all sales, ostensibly for tax purposes. As part of this regulatory process, users had to obtain prescriptions. Even though the Act specifically provided that doctors could prescribe narcotics, they could only do so if it was in the course of their "professional practice."

There were court challenges to the legislation. However, the U.S. Supreme Court upheld the *Harrison Act* as a revenue act and not a policing measure.[212] It was subsequently held that the Act did not permit physicians to prescribe drugs to "addicts" to keep them physically comfortable or maintain their addiction.[213] The *Behrman* decision[214] of 1922 further restricted the ability of physicians to prescribe and the prosecution of pharmacists and physicians resulted in legal supplies of opiates and other drugs essentially becoming unavailable by the early 1920s.

Subsequent measures

In the Depression years, fears about "degenerate Mexicans" smoking marijuana also led to legislative action. Some suggest that this represents a common thread in American drug policy; that is, the determining factor in deciding whether a particular drug was criminalized was not its inherent properties or potential for social harm, but rather the kinds of people associated with its use.[215] By 1931, 29 states had outlawed marijuana and in 1937 Congress passed the *Marihuana Tax Act* which, like the *Harrison Act*, established federal control over marijuana pursuant to Congress' revenue authority. Although opposed by the American Medical Association at the time, the Act had the support of the country's top drug cop, the head of the Federal Bureau of Narcotics (FBN), Henry J. Anslinger.

---

212 *United States v. Doremus* (1919), 249 U.S. Reports 86. The *Harrison Act* was again upheld as a revenue measure in *United States v. Nigro* (1928), 276 U.S. Reports 332.

213 *Webb et al. v. United States* (1919), 249 U.S. Reports 96.

214 *United States v. Behrmann* (1922), 258 U.S. Reports 280.

215 See Luna, *supra*, page 490-495.

Anslinger, a central figure in the history of American drug policy, had been named the commissioner of the FBN in 1930 and headed the organization through five presidential administrations, until 1962. Often compared to his contemporary J. Edgar Hoover, who controlled the FBI. with similar tenacity, Anslinger did not support a public health approach to drug policy and argued that jailing users was the only proper response. He often suggested that drugs were part of a foreign plot. During W.W.II, he accused the Japanese of using narcotics to sap America's will to fight; following the war, he asserted that it was the Communists who were attempting to do so.

Current legislation and enforcement

Federal law

The Controlled Substances Act

In 1970 the U.S. Congress enacted the federal Controlled Substances Act (the CSA) [216] pursuant to the federal authority to regulate interstate commerce.[217] This Act repealed most of the earlier federal legislation, including the *Harrison Act* and the *Marihuana Tax Act,* and is the foundation of U.S. federal drug law today. Based on a series of schedules, drugs are categorized and controlled to varying degrees. The most restrictions are placed on Schedule I drugs which cannot be possessed by anyone, except for the purpose of research that has been licensed by the federal government. This schedule includes drugs such as marijuana, heroin, MDMA, LSD and peyote which are deemed to have no medical use and a high abuse potential. Schedule II substances, which have an accepted medical use and are deemed to have an abuse potential less than those in Schedule I, are also subjected to tight controls. Included in Schedule II are cocaine, opium, morphine, meperidine (Demerol) and codeine.

The enactment of the CSA in 1970 represented a significant change in one key respect. Marijuana was differentiated from other drugs and federal penalties were reduced, not only for possession, but also for trafficking and distribution offences. This was to change, however, during the Reagan administration in the 1980s.

In 1982 President Reagan signed an executive order creating the post of White House Drug Policy Advisor. The *Comprehensive Crime Control Act* of 1984, the *Anti-Drug Abuse Act* of 1986 and the *Anti-Drug Abuse Amendment Act* of 1988 raised federal penalties for various drug-related offences (including marijuana offences), increased funding for drug control activities and sought to improve the coordination of federal drug control efforts. The *National Narcotics Leadership Act* of 1988 created the Office of

[216] Comprehensive Drug Abuse Prevention and Control Act of 1970, Title II, 21 U.S.C., ss. 800-966.

[217] Congress need merely find that a class of activity affects interstate commerce to enact criminal penalties; no proof is required that the conduct involved in a single prosecution has an effect on commerce: see Ehrlich, Susan, "The Increasing Federalization of Crime" (2000) 32 Ariz. St.L.J.825.

National Drug Control Policy, the director of which is commonly referred to as the "Drug Czar."[218]

Many commentators have suggested that these laws were passed during a time of extreme anti-drug hysteria resulting from the introduction of crack cocaine.[219] Propagated by politicians and embraced by the mainstream media, myths regarding crack likely had a significant impact on the increased use of mandatory minimum sentences and the expansion of the American "war on drugs" during the Reagan era.

Scheduling under the CSA–the example of marijuana

An examination of a petition to the Drug Enforcement Administration to reschedule marijuana is instructive of the scheduling process under the CSA.[220] In concluding that marijuana should remain in Schedule I, the Department of Justice considered eight factors:

- The drug's actual or relative potential for abuse;
- Scientific evidence of its pharmacological effects;
- The state of current scientific knowledge of the drug;
- Its history and current pattern of abuse;
- The scope, duration and significance of abuse;
- What, if any, risk there is to public health;
- The drug's psychic or physiological dependence liability; and,
- Whether the drug is an immediate precursor of a substance already controlled under the CSA.

The petition to reschedule was denied in part on the basis that marijuana has a high potential for abuse. While the term "abuse" is not defined in the CSA, the administration examined various factors in ascertaining the potential for abuse. Most important was its finding that individuals are taking the substance in amounts sufficient to create a hazard to their health or to the safety of other individuals or the community. It was determined that while marijuana has low levels of toxicity compared to other drugs of abuse, there are a number of risks resulting from both acute and chronic use, such as dizziness, nausea, time distortions, impaired judgement and short-term memory impairment. Also noted were studies from some authors who described a "marijuana withdrawal syndrome" consisting of restlessness, mild agitation, insomnia, nausea and cramping that resolves within days.

---

218 The Office's home page can b e found at www.whitehousedrugpolicy.gov.

219 See, for example, Craig Reinarman and Harry G. Levine, eds., *Crack in America: Demon Drugs and Social Justice*, University of California Press, September 1997. The organization Human Rights Watch in a May 2000 report on the United States referred to the phenomenon as a "moral panic" (available online at www.hrw.org/reports/2000/usa).

220 Department of Justice, Drug Enforcement Agency, "Notice: Denial of Petition", April 18, 2001, in Vol. 66, No. 75 of the Federal Register, page 20037-20076.

Another significant element of the analysis that precluded rescheduling marijuana was the fact that the drug has no currently accepted medical use in the United States. The Food and Drug Administration has not yet authorized treatment using marijuana. To do so would require that the following conditions be satisfied:

- The drug's chemistry must be known and reproducible;
- There must be adequate safety studies;
- There must be adequate and well-controlled studies proving efficacy;
- The drug must be accepted by qualified experts; and,
- The scientific evidence must be widely available.

Proposed legislation

The legislative war on drugs continues in the U.S. Congress. The proposed *Drug Dealer Liability Act of 1999* passed in the U.S. House of Representatives and was received in the Senate at the end of 2000. It would impose civil liability on drug dealers for the harm caused–either directly or indirectly–by the use of controlled substances. Even the drug users themselves would be permitted to sue for damages, although the statute requires that they first disclose to narcotics enforcement officers everything they know about the source of the illegal drugs. While it is not clear whether this bill will be made law, a model *Drug Dealer Liability Act* has so far been adopted by 13 states.[221]

Legislation entitled the *Protecting Our Children from Drugs Act of 2000* was passed by the House of Representatives on 17 October 2000. It would amend the *Controlled Substances Act* to further increase penalties for drug dealers who involve children in the drug trade. Mandatory minimum sentences would increase for dealers who use children under 18 to distribute drugs in or near schools or other "protected locations" such as playgrounds and video arcades. Other proposed initiatives include the *Drug Free America Act of 2001*, the *Domestic Narcotic Demand Reduction Act of 2001* and the *Drug Treatment and Research Enhancement Act of 2001*.

Federal penalties

The following charts provide a summary of the fines and the terms of imprisonment for selected violations of the federal *Controlled Substances Act* and related federal laws.[222] Note that for a third felony drug offence involving amounts constituting a top level offence, there is a mandatory life sentence without the possibility of release. Also note that the indicated weights refer to any mixture containing a detectable

---

[221] Arkansas, California, Colorado, Georgia, Hawaii, Illinois, Indiana, Louisiana, Michigan, Oklahoma, South Carolina, South Dakota, Utah and the U.S. Virgin Islands.

[222] Congress has passed various anti-crime bills that include drug-related provisions, including the *Crime Control Act* of 1984 (P.L. 98-473), the *Anti-Drug Abuse Act* of 1986 (P.L. 99-570), the *Anti-Drug Abuse Act* of 1988 (P.L. 100-690), the *Crime Control Act* of 1990 (P.L. 101-647) and the *Violent Crime Control and Law Enforcement Act* of 1994 (P.L. 103-322). Collectively, these Acts enhanced drug-related penalties and provided new funding for drug control activities.

amount of the illegal drug regardless of the substance in the mixture. "Conspiracy" and "attempt" offences carry the same penalties as the underlying offence.

Table 1[223]

Unlawful distribution, possession with intent to distribute, manufacture, importation and exportation				
Substance	Offence Number	Amount of Drug	Fine (in dollars)	Imprisonment
Heroin	First Offence	1 kg or more	4-10 million	10 years to life
		100 g – 1 kg	2-5 million	5-40 years
		Less than 100 g	1-5 million	Up to 20 years
	Second Offence[224]	1 kg or more	8-20 million	20 years to life
		100 g – 1 kg	4-10 million	10 years to life
		Less than 100 g	2-10 million	Up to 30 years
Coca leaves, Cocaine or "Crack"	First Offence	50 g or more	4-10 million	10 years to life
		5-50 g	2-5 million	5-40 years
		Less than 5 g	1-5 million	Up to 20 years
	Second Offence	50 g or more	8-20 million	20 years to life
		5-50 g	4-10 million	10 years to life
		Less than 5 g	2-10 million	Up to 30 years
LSD	First Offence	10 g or more	4-10 million	10 years to life
		1-10 g	2-5 million	5-40 years
		Less than 10 g	1-5 million	Up to 20 years
	Second Offence	10 g or more	8-20 million	20 years to life
		1-10 g	4-10 million	10 years to life
		Less than 10 g	2-10 million	Up to 30 years
Marijuana	First Offence	1,000 kg or more or 1,000 plants or more	4-10 million	10 years to life
		100-1,000 kg or 100-1,000 plants	2-5 million	5-40 years
		50-100 kg or 100 plants	1-5 million	Up to 20 years
		Under 50 kg[225]	250,000-1 million	Up to 5 years
	Second Offence	1,000 kg or more or 1000 plants or more	8-20 million	20 years to life
		100-1,000 kg or 100-1,000 plants	4-10 million	10 years to life

[223] Source: Charles Doyle, *Drug Offences: Maximum Fines and Terms of Imprisonment for Violation of the Federal Controlled Substances Act and Related Laws*, Library of Congress Congressional Research Service, November 1, 2000.

[224] A second offence is one committed after a prior conviction for *any* felony drug offence under *any* federal, state or foreign drug law.

[225] Distribution of a small amount of marijuana for no remuneration is treated as simple possession, the penalties for which are contained in the second chart.

Unlawful distribution, possession with intent to distribute, manufacture, importation and exportation				
Substance	Offence Number	Amount of Drug	Fine (in dollars)	Imprisonment
		50-100 kg or 100 plants	2-10 million	Up to 30 years
		Under 50 kg	500 000-2 million	Up to 10 years

Table 2

Simple possession				
Drug	Offence Number	Amount of Drug	Fine (in dollars)	Imprisonment
Cocaine based	First	Over 5 g	Up to 250,000	5-20 years
	First	5 g or less	Minimum 1,000	Up to 1 year
All other	First	All amounts		
Cocaine based	Second[226]	Over 3 g	Up to 250,000	5-20 years
All other	Second	All amounts	Minimum 2,500	15 days to 2 years
Cocaine based	Third	Over 1 g	Up to 250,000	5-20 years
All other	Third	All amounts	Minimum 5,000	90 days to 3 years

State laws

General

In the U.S. a group called the National Conference of Commissioners on Uniform State Law has the task of drafting legislation that is to be recommended for adoption by all states in an effort to promote legislative consistency throughout the nation. The most recent Uniform Controlled Substances Act was drafted in 1994. The Act sets out the prohibited activities in detail but specific fines and sentencing are left to the discretion of the individual States. Most states have substantially adopted the major provisions of the Uniform Act[227] with the exception of New Hampshire and

226 A prior conviction includes conviction of *any* offence under the *Controlled Substances Act* or any State drug law.

227 The *Uniform Laws Annotated*, Master Edition, Volume 9, Parts II, III and IV, provides annotation materials for the adopting states. Under the heading "General Statutory Note", those jurisdictions that have based their drug legislation on the *Uniform Act* are stated to have substantially adopted the major provisions of the *Uniform Act*, but the official text of the State Act "departs from the official text in a such manner that the various instances of substitution, omission, and additional material cannot be clearly indicated by statutory notes." As such, it is recommended that recourse be had to the individual State legislation for specific details for the individual CSA. Another useful reference is Richard A. Leiter, ed., *National Survey of State Laws, 3rd Ed.*, Detroit: Gale Group, 1999, which, at pages 152-188, provides charts that set out specific offences and penalties for cocaine, heroin and marijuana in all States.

Vermont where the state laws are not a substantial adoption of the Uniform CSA, although they contain some similar provisions and have the same general purpose. Also of note are the medical marijuana exemptions discussed below.

In terms of sentencing, there are significant discrepancies between states.[228] With respect to sentencing for other drug offences, some states have experimented with extremely harsh penalties. New York's "Rockefeller Laws," for example, are referred to herein in the section entitled "Key Reports and Studies." Other states that adopted similar "get-tough" penalties are now re-examining mandatory minimums, often as a result of fiscal considerations. For example, the state legislature in Louisiana overhauled its drug laws in June 2001. New legislation has cut drug sentences and repealed mandatory minimums for many non-violent crimes. As one republican legislator was quoted as saying, "*It's costing us too much to lock these people up and throw away the key.*"

Medical marijuana

Since 1978, medical marijuana laws have been enacted in 35 states. Five have since expired or been repealed but the balance remain on the books. Of those remaining:

- 12 states have "Therapeutic Research Program" laws that purport to permit scientific research (although this is complicated by the federal prohibition).
- 10 states (and the District of Columbia) have symbolic laws that recognize the potential medicinal value of marijuana, but do not provide any protection from arrest.
- 8 states have laws that effectively allow patients to use medical marijuana despite federal law.

The following chart provides details of the eight states with effective medical marijuana laws. While marijuana possession is still a federal crime, most drug arrests are made by state and local officials. Since the federal government cannot force state and local police to enforce federal statutes, medical marijuana users are usually able to avoid prosecution in these states. However, since pharmacies do not sell marijuana, some distribution centres called "buyers' clubs" have emerged and these operations have been hampered by federal law enforcement.

Recently, the Supreme Court examined the issue of buyers' clubs in *Conant v. Oakland Cannabis Buyers' Cooperative*.[229] The court unanimously ruled that there is no medical necessity defence to the Controlled Substances Act's prohibitions on manufacturing and distributing marijuana. Because the CSA classifies marijuana as a Schedule I drug, marijuana has been deemed to have no medical benefits. While the decision in *Conant* does not render state laws regarding medical marijuana inoperative, it

---

[228] Appendix 2 of the report by B. Dolin, *op. cit.*, states the main alternatives.

[229] No. 00-151. Argued March 28, 2001 – Decided May 14, 2001. Cited as: 532 U.S. __ (2001).

does enhance the federal government's ability to prosecute under the CSA in all states. That said, federal enforcement efforts have not, thus far, targeted individuals who possess or cultivate small amounts for medical use. Only the buyers' clubs (also known as "compassion clubs") have been targeted.

In respect of the following chart, it should be noted that the quantity of marijuana a patient may possess varies from state to state. The provisions exempting caregivers from criminal liability may also vary.

State and Date Enacted	Protection provided to Patients	Documentation Required
Alaska – 3 Nov. 1998	Affirmative defence[230] provided to those registered with the state	Signed physician statement confirming that patient was examined, has a debilitating medical condition and other
California – 5 Nov. 1996	Exemption from prosecution if marijuana possession or cultivation is solely for the medical purposes of the patient	Written or oral approval by physician who has determined that the patient's health would benefit from marijuana in the treatment of a qualifying
Colorado – 7 Nov. 2000	Exemption from prosecution if in possession of a registry card; affirmative defence if no card, but in compliance with	Diagnosed prior to arrest as having a debilitating condition and advised by the physician that marijuana might benefit
Hawaii – 14 June 2000	Exemption from prosecution if in possession of a registry card; "choice of evils" defence also available[231]	Card obtained with medical records or a statement from a physician that there is a debilitating condition and the potential benefits of marijuana would "likely outweigh the
Maine – 2 Nov. 1999	Burden on state to p rove that patient's medical use was not authorized by statute	Medical records or physician's letter showing that the patient has a qualifying condition, that the risks have been discussed and that the patient "might benefit" from medical marijuana
Nevada – 7 Nov. 2000	Exemption from prosecution	"Advice required"; specifics yet to be determined by legislature
Oregon – 3 Nov. 1998	Exemption from prosecution if in possession of registry card; affirmative defence if no card, but in compliance with the law; choice of evils	Diagnosed within 12 months of arrest with a qualifying condition and advised by attending physician that marijuana "may mitigate the

[230] An "affirmative defence" requires the defendant to prove on a balance of probabilities tha t he or she is in compliance with the statute.

[231] The "choice of evils" deference refers to the defence of medical necessity. Long recognized in common law, a defendant is provided the opportunity to prove in court that his or her violation of the law was necessary to avert a greater evil; the pain of a debilitating disease or condition in the case of medical marijuana. Certain states, as noted in the chart, have codified the defence.

State and Date Enacted	Protection provided to Patients	Documentation Required
Washington – 3 Nov. 1998	Exemption from prosecution if patient qualifies, has no more marijuana than necessary for personal medical use and presents valid documentation to law enforcement; affirmative defence if in compliance with	Signed physician statement or medical records that indicate that physician is of the opinion that the "potential benefits" of marijuana "would likely outweigh the health risks"

Federal drug policy goals and objectives

National drug-control policy in the United States purports to be based upon prevention, education, treatment and research, complemented by "supply reduction" activities.[232] To quote from the 2001 Annual Report of the Office of National Drug Control Policy ("ONDCP"):

> *Through a balanced array of demand-reduction and supply-reduction actions, we strive to reduce drug abuse and availability by half and the consequences of drug abuse by at least 25% by 2007.*[233]

Using the metaphor of cancer for the nation's drug problem, the ONDCP lists the following strategic goals and objectives as being the heart of American federal action in this area.[234]

Goal 1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.

Objective 1: Educate parents and other care givers, teachers, coaches, clergy, health professionals, and business and community leaders to help youth reject illegal drugs and underage alcohol and tobacco use.

Objective 2: Pursue a vigorous advertising and public communications program dealing with the dangers of illegal drugs, alcohol, and tobacco use by youth.

Objective 3: Promote zero tolerance policies for youth regarding the use of illegal drugs, alcohol, and tobacco within the family, school, workplace, and community.

Objective 4: Provide students in grades K-12 with alcohol, tobacco, and drug prevention programs and policies that are research based.

---

232 *National Drug Control Strategy: 2001 Annual Report*, Office of National Drug Control Policy, page 3.
233 *Ibid.*, page 4.
234 Available online at:
http://www.whitehousedrugpolicy.gov/publications/policy/99ndcs/goals.html.

Objective 5: Support parents and adult mentors in encouraging youth to engage in positive, healthy lifestyles and modeling behavior to be emulated by young people.

Objective 6: Encourage and assist the development of community coalitions and programs in preventing drug abuse and underage alcohol and tobacco use.

Objective 7: Create partnerships with the media, entertainment industry, and professional sports organizations to avoid the glamorization, condoning, or normalization of illegal drugs and the use of alcohol and tobacco by youth.

Objective 8: Develop and implement a set of research-based principles upon which prevention programming can be based.

Objective 9: Support and highlight research, including the development of scientific information, to inform drug, alcohol, and tobacco prevention programs targeting young Americans.

Goal 2: Increase the safety of America's citizens by substantially reducing drug-related crime and violence.

Objective 1: Strengthen law enforcement – including federal, state, and local drug task forces – to combat drug-related violence, disrupt criminal organizations, and arrest and prosecute the leaders of illegal drug syndicates.

Objective 2: Improve the ability of High Intensity Drug Trafficking Areas (HIDTAs) to counter drug trafficking.

Objective 3: Help law enforcement to disrupt money laundering and seize and forfeit criminal assets.

Objective 4: Break the cycle of drug abuse and crime.

Objective 5: Support and highlight research, including the development of scientific information and data, to inform law enforcement, prosecution, incarceration, and treatment of offenders involved with illegal drugs.

Goal 3: Reduce health and social costs to the public of illegal drug use.

Objective 1: Support and promote effective, efficient, and accessible drug treatment, ensuring the development of a system that is responsive to emerging trends in drug abuse.

Objective 2: Reduce drug-related health problems, with an emphasis on infectious diseases.

Objective 3: Promote national adoption of drug-free workplace programs that emphasize a comprehensive program that includes: drug testing, education, prevention, and intervention.

Objective 4: Support and promote the education, training, and credentialing of professionals who work with substance abusers.

Objective 5: Support and promote the education, training, and credentialing of professionals who work with substance abusers.

Objective 6: Support and highlight research and technology, including the acquisition and analysis of scientific data, to reduce the health and social costs of illegal drug use.

Objective 7: Support and disseminate scientific research and data on the consequences of legalizing drugs.

Goal 4: Shield America's air, land, and sea frontiers from the drug threat.

Objective 1: Conduct flexible operations to detect, disrupt, deter, and seize illegal drugs in transit to the United States and at U.S. borders.

Objective 2: Improve the coordination and effectiveness of U.S. drug law enforcement programs with particular emphasis on the Southwest Border, Puerto Rico, and the U.S. Virgin Islands.

Objective 3: Improve bilateral and regional cooperation with Mexico as well as other cocaine and heroin transit zone countries in order to reduce the flow of illegal drugs into the United States.

Objective 4: Support and highlight research and technology – including the development of scientific information and data – to detect, disrupt, deter, and seize illegal drugs in transit to the United States and at U.S. borders.

Goal 5: Break foreign and domestic drug sources of supply.

Objective 1: Produce a net reduction in the worldwide cultivation of coca, opium, and marijuana and in the production of other illegal drugs, especially methamphetamine.

Objective 2: Disrupt and dismantle major international drug trafficking organizations and arrest, prosecute, and incarcerate their leaders.

Objective 3: Support and complement source country drug control efforts and strengthen source country political will and drug control capabilities.

Objective 4: Develop and support bilateral, regional, and multilateral initiatives and mobilize international organizational efforts against all aspects of illegal drug production, trafficking, and abuse.

Objective 5: Promote international policies and laws that deter money laundering and facilitate anti-money laundering investigations as well as seizure and forfeiture of associated assets.

Objective 6: Support and highlight research and technology, including the development of scientific data, to reduce the worldwide supply of illegal drugs.

Administration of the policy

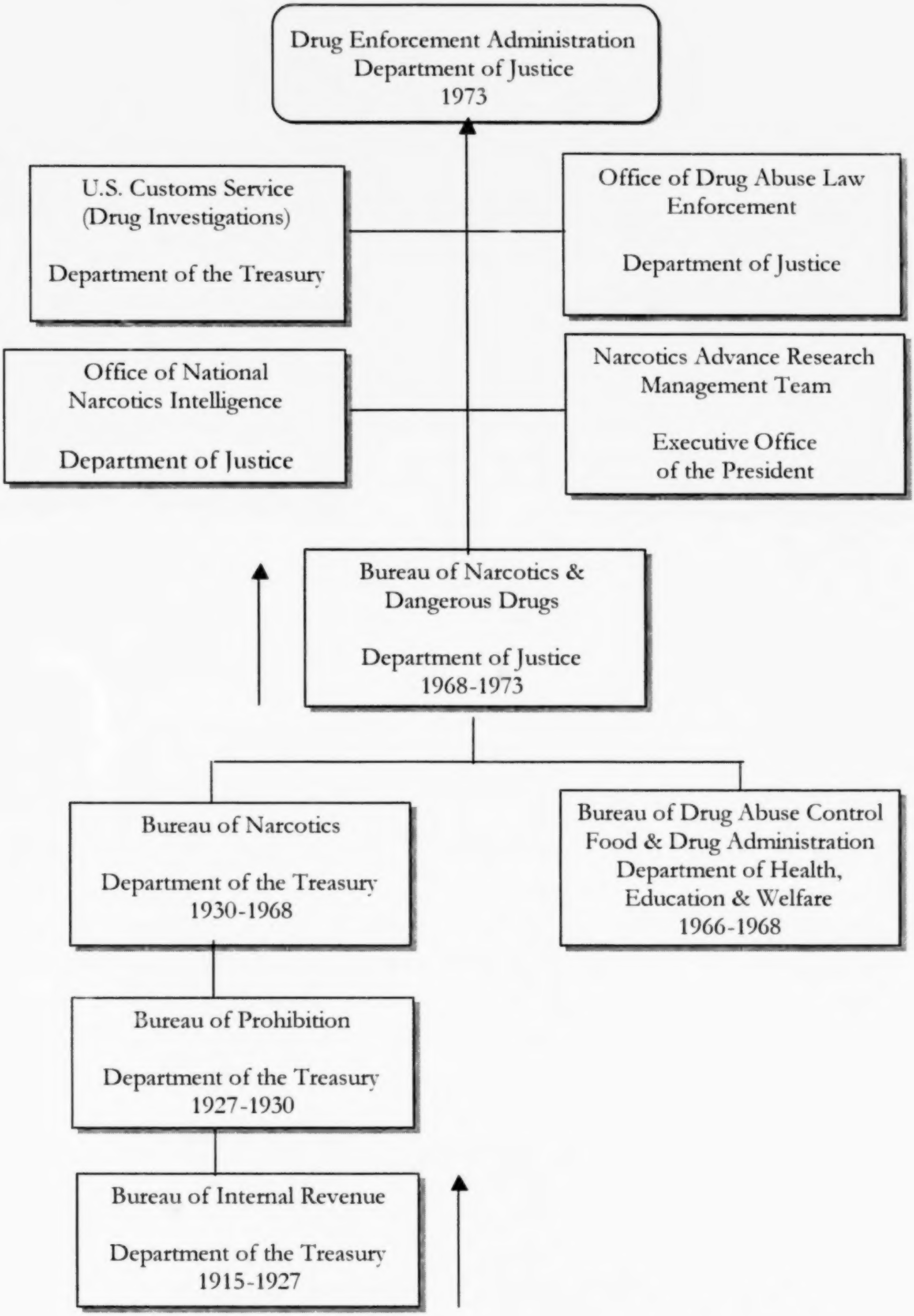
As previously stated, the national drug control budget is enormous. Over $18 billion has been budgeted for the year 2001 for the purpose of supporting the goals and objectives of the National Drug Control Strategy. Numerous federal departments, including Defense, Education, Justice, State and the Treasury, are involved and often must coordinate with state and local government agencies and a wide assortment of community and professional groups. This is all overseen by the ONDCP.

A key government department is the Department of Justice which is responsible for many of the agencies involved in this area and receives a significant portion of the drug control budget; over 8 billion dollars in 2001.[235] Various agencies receive funding through Justice, including the Bureau of Prisons, the F.B.I., INTERPOL, the U.S. Marshals Service, the Immigration and Naturalization Service and the Drug

[235] Source: Executive Office of the President of the United States, *Summary: FY 2002 National Drug Control Budget*, April 2001, page 11.

Enforcement Agency (DEA). The DEA[236] merits special mention in the Justice Department's administration of drug control policy. Its mission is to enforce the controlled substances laws and regulations and to recommend and support non-enforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets. Established in 1973, it is the successor of Anslinger's FBN and other enforcement arms of the federal government as illustrated in the following graphic.[237]

[236] The DEA's Web page is at http://www.usdoj.gov/dea/.
[237] Source: DEA Web site, at http://www.usdoj.gov/dea/agency/genealogy.htm.


Drug Enforcement Administration
Department of Justice
1973
U.S. Customs Service
(Drug Investigations)
Department of the Treasury
Office of Drug Abuse Law Enforcement
Department of Justice
Office of National Narcotics Intelligence
Department of Justice
Narcotics Advance Research Management Team
Executive Office of the President
Bureau of Narcotics & Dangerous Drugs
Department of Justice
1968-1973
Bureau of Narcotics
Department of the Treasury
1930-1968
Bureau of Drug Abuse Control
Food & Drug Administration
Department of Health, Education & Welfare
1966-1968
Bureau of Prohibition
Department of the Treasury
1927-1930
Bureau of Internal Revenue
Department of the Treasury
1915-1927

Apart from its law enforcement duties, the DEA manages national drug intelligence and is responsible, under the policy guidance of the Secretary of State and U.S. Ambassadors, for all programs associated with drug law enforcement counterparts in foreign countries. In this capacity, the organization liases with the United Nations, Interpol, and other organizations on matters relating to international drug control programs. American actions outside of U.S. territory include "Plan Columbia," a program targeted at reducing cocaine productivity in that country to which over a billion dollars has been committed, as well as well joint enforcement activities undertaken with other governments such as Mexico. As well, under the *Foreign Assistance Act*, the U.S. is required to impose substantial restrictions on bilateral assistance to those countries listed by the White House as being major drug producing or transit countries. Similarly, the *Foreign Narcotics Kingpin Designation Act* permits the President to designate foreign individuals as "drug kingpins," thereby denying them access to the U.S. financial system and making illegal any transactions between the "kingpin" and U.S. companies or individuals.

Current issues and debates

The costs of incarceration, the unequal impact of drug laws on racial minorities and police corruption resulting from the war on drugs are issues that have garnered increased attention in this ongoing debate. For example, the Republican Governor of New Mexico has called for the decriminalization of all drugs – "*Control it, regulate it, tax it!*" he has been quoted as saying[238] – citing the mounting cost of addressing drug abuse problems with prison rather than treatment. At our hearings, the Governor told us:

> *I happen to believe that the war on drugs is an absolute miserable failure. (...) When I witness that half of what we spend on law enforcement, half of what we spend on the courts and half of what we spend on the prisons is drug related, I know that there is no bigger issue facing us today. In the United States we are spending $50 billion each year on drug-related crime. (...) Two-thirds of all prisoners in the United States are incarcerated on drug charges. Nearly 500,000 incarcerations, one-quarter of the prison population, are directly related to drugs. It costs over $8.6 billion each year just to keep drug offenders locked up in the United States. Even with all of those expenditures, illegal drugs are now cheaper, more available and more potent than they were 20 years ago.*
>
> *(...) In the United States, which one of these substances gets people arrested? We are arresting 1.6 million people every year. New Mexico has a population of 1.8 million. I live and I drive in New Mexico, a giant state, and I cannot help but think the equivalent of the population of New Mexico is getting arrested in the United States every single year. It's absolutely shocking. Out of those 1.6 million arrests, there are 800,000 for marijuana, and half of those arrests involve Hispanics. Are half the users of marijuana in the United States Hispanic? No, yet half the arrest disproportionally fall on the Hispanic communities.*

---

[238] "New Mexico Governor Calls for Legalizing Drugs", CNN.com, October 6, 1999, available online at www5.cnn.com/US/9910/06/legalizing.drugs.01/.

> *Given that situation, what do we need to do? First, we need to legalize marijuana. Second, we need to adopt harm reduction strategies with regard to all the other drugs. Third, we need to move away from a criminal model to a medical model.*[239]

Others criticize current policy on the basis that black Americans are disproportionately targeted in drug law enforcement. The group Human Rights Watch notes in a 2000 study that Blacks comprise 62.7% and whites 36.7% of all drug offenders admitted to state prisons, even though data confirms that this racial disparity "bears scant relation to racial differences in drug offending."[240] Various experts also pointed out the harmful effect of drugs on law enforcement, in particular Mr. Joseph McNamara, former chief of police of San Jose, California, now retired, who noted that the corruption of civil servants will be a serious problem as long as the current anti-drug policy remains in effect.[241]

Statistics

In Chapter 6, we presented an overview of data on cannabis use. We round out th description of the situation in the United States with a number of tables on certain selected indicators.

Estimated Domestic U.S. Drug Consumption (in Metric Tons)[242]

Year	Cocaine	Heroin	Marijuana	Methamphetamine
1996	288	12.4	874	14.3
1997	312	13.1	960	11.9
1998	291	12.5	952	15.9
1999	276	12.9	982	15.5
2000	269	12.9	1,009	15.5

---

239 Testimony of Mr. Gary E. Johnson, Governor of New Mexico, before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, November 5, 2001, Issue 9, page 36 to 38.

240 Jamie Fellner, Human Rights Watch Associate Counsel, "United States: Punishment and Prejudice: Racial Disparities in the War on Drugs", Human Rights Watch, May 2000, paragraph 2 of "Summary and Recommendations", available online at www.hrw.org/reports/2000/usa.

241 Joseph D. McNamara, "When Cops Become the Gangsters", *Los Angeles Times*, September 21, 1999, available online at www.nakedgov.com/mcnamara.htm.

242 Source: Office of National Drug Control Policy, 2000. *What America's Users Spend on Illegal Drugs, 1988-1998.*

1997 National Household Survey on Drug Abuse: Past Illicit Drug Use[243]

Respondent Age	Ever Used	Past Year	Past Month
12 – 17	23.7 %	18.8 %	11.4 %
18 – 25	45.4 %	25.3 %	14.7 %
26 – 34	50.8 %	14.3 %	7.4 %
35 and over	31.5 %	6.1 %	3.6 %

1998 Drug Use Amount High School Seniors[244]

Drug	Ever Use	Past Year	Past Month
Marijuana	49.1 %	37.5 %	22.8 %
Cocaine	9.3 %	5.7 %	2.4 %
Crack	4.4 %	2.5 %	1 %
Stimulants	16.4 %	10.1 %	4.6 %
LSD	12.6 %	7.6 %	3.2 %
PCP	3.9 %	2.1 %	1 %
Heroin	2 %	1 %	0.5 %

Drug Prices and Purity Levels: Selected Years 1981-1998[245]

Purchase Amount	1981 Price/Purity (per pure gram)	1988 Price/Purity **(per pure gram)**	1996 Price/Purity (per pure gram)	1997 Price/Purity (per pure gram)	1998 Price/Purity (per pure gram)
Cocaine					
1 g or less	$378.70/40.02%	$218.33/75.99%	159.05/72.5 %	$178.97/64.72%	$169.25/71.23%
10-100 g	191.5/59.59%	78.84/ 83.53%	49.45/ 68.44p. cent	45.58/67.05	44.30/65.92
Heroin					
0.1 g or less	3,114.80/4.69	2,874.19/19.22	2,175.88/23.95	2,114.97/25.24	1,798.80/24.29
1-10 g	1,194.05/19.1	947.32/39.48	373.30/45.21	327.88/45.38	317.97/51.33
Marijuana					
10 g or less	$6.41	$12.50	$10.42	$10	$10.41
100-999 g	2.75	3.41	2.95	2.63	2.59

243 Source: Office of National Drug Control Policy, Drug Policy Information Clearinghouse. *Drug Data Summary*, April 1999.

244 *Ibid.*

245 *Ibid.*

National Drug Control Budget[246]

Year	Amount (in $US billions)
1999	17.1
2000	17.9
2001	18.1
2002	19.2

Total Estimated Arrests and Drug Arrests, 1989-1999[247]

Year	Total Arrests	Arrests for all drug violations		Distribution of arrests for drug violations					
				Heroin/Cocaine		Marijuana		Other Drugs	
		Number	Per-cent	Sale	Possession	Sale	Possession	Sale	Possession
1989	14 340 900	1,351,700	.4	19.1	34.7	6.2	23.1	7.0	9.8
1990	14 195 100	1,089,500	.6	21.0	33.3	6.1	23.9	4.5	11.2
1991	14 211 900	1,010,000	.1	22.5	32.8	6.1	22.4	4.8	11.5
1992	14 075 100	1,066,400	.5	20.6	32.4	6.6	25.5	4.6	10.4
1993	14 036 300	1,126,300	.0	19.2	31.1	6.2	27.6	4.3	11.6
1994	14 648 700	1,351,400	.2	16.8	30.3	5.8	29.8	4.1	13.2
1995	15 119 800	1,476,100	.7	14.7	27.8	5.8	34.1	4.4	13.3
1996	15 168 100	1,506,200	.9	14.2	25.6	6.3	36.6	4.3	13.3
1997	15 284 300	1,583,600	0.3	10.3	25.4	5.6	38.3	4.7	15.8
1998	14 528 300	1,559,100	0.7	11	25.6	5.4	38.4	4.8	14.8
1999	14 031 070	1,532,200	0.9	10	24.5	5.5	40.5	4.1	15.4

[246] These figures represent funds specified for the purpose of supporting the goals and objectives of the National Drug Control Strategy and include funds budgeted for various departments, including Defence, Education, Justice, State, and Treasury,. Source: *National Drug Control Budget Executive Summary, Fiscal Year 2002*, Office of National Drug Control Policy, April 9, 2001.

[247] Source: *Crime in the United States: Uniform Crime Reports*, U.S. Department of Justice, Federal Bureau of Investigation (1990-2000).

Adults in Custody of State or Federal Prisons or Local Jails, 1989-1999[248]

Year	State Prisons	Federal Prisons	Total State & Federal Prisons	Percent of prisoners who are drug offenders		Local Jails
				Federal	State	
1989	629,995	53,387	683,382	49.9	19.1	395,553
1990	684,544	58,838	743,382	53.5	21.7	405,320
1991	728,605	63,930	792,545	55.9	21.3	426,479
1992	778,495	72,071	850,566	58.9	22.1	444,584
1993	828,566	80,815	909,381	59.2	22.1	459,804
1994	904,647	85,500	990,147	60.5	22.4	486,474
1995	989,004	89,538	1,078,542	59.9	22.7	507,044
1996	1,032,440	95,088	1,127,528	60.0	22.7	518,492
1997	1,059,588	99,175	1,176,922	62.6	20.7	567,079
1998	1,178,978	123,041	1,232,900	58.7	20.7	592,462
1999	1,209,123	135,246	1,366,369	57.8	Unavailable	605,943

Correctional population in the United States: selected statistics for 1997[249]

In 1997, an estimated 5.7 million adult residents of the U.S. (or approximately 2.8% of all U.S. adult residents) were under some form of correctional supervision. Approximately 70% were supervised in the community, through probation or parole. About 9.0% of black adults were under correctional supervision; for white adults, the figure was 2.0% and for other races it totalled 1.3%.

Federal drug prosecutions: selected statistics for 1999[250]

During 1999 U.S. attorneys initiated investigations involving 117,994 suspects. Of these suspects, 32% were investigated for drug offences. Suspects in criminal matters involving drug offences were more likely to be prosecuted in a U.S. district court (77%) as opposed to suspects involved in violent offences (59%), public order offences (53%) or property offences (50%). Of those convicted of felony drug offences in federal court in 1999, 93% received prison sentences. The average sentence of all offenders sentenced in federal court in 1999 was 57.8 months; for drug offenders, the average was 75.4 months.

---

[248] Sources: Bureau of Justice Statistics Bulletin, *Prisoners in 1999* (Aug. 2000), *Prisoners in 1998* (Aug. 1999), *Prisoners in 1997* (Aug. 1998), *Correctional Populations in the United States*, 1995, 1994, 1993, 1992, 1991, 1990, 1989. *Jails and Jail Inmates*, 1993-94. *Jail Inmates*, 1992; 1990. Data for 1997 percentages of drug offenders are estimated from Bureau of Justice Statistics, *Substance Abuse and Treatment, State and Federal Prisoners, 1997* (January 1999) and unpublished Bureau of Prisons Data.

[249] Source: *Correctional Populations in the United States, 1997*, Bureau of Justice Statistics, U.S. Department of Justice, (November 2000).

[250] Source: *U.S. Compendium of Federal Judicial Statistics, 1999*, (April 2001).

DEA seizures of non-drug property – 1997[251]

In fiscal year 1997, the Drug Enforcement Agency made 15,860 seizures of non-drug property pursuant to drug forfeiture laws. The total value of this property is estimated at $552 million.

Property Type	Number of Seizures	Value (in dollars)
Cash	8,123	284,680,029
Other financial instruments	507	73,602,092
Real property	748	108,833,498
Vehicles	3,695	47,379,874
Boats	111	5,884,754
Aircraft	24	8,945,000
Other means of transportation	172	1,734,731
Other	2,480	1,734,731

[251] Source: Official of National Drug Control Policy, Drug Policy Information Clearinghouse, *Drug Data Summary*, April 1999.

CHAPTER 21

PUBLIC POLICY OPTIONS

Public policy is not just a matter of enabling legislation, in this case criminal legislation. Nonetheless, when it comes to illegal drugs, criminal legislation occupies a symbolic and determinative place in public policy. It is as if this legislation is the backbone of our public policy. Public discussions of cannabis do not deal so much with such matters as public health, user health, prevention of at-risk or excessive use, but with such questions as the pros and cons of decriminalization, establishing a civil offence or maintaining a criminal offence, or possible legalization and the extent thereof. As we complete our report, the Minister of Justice is releasing trial balloons in relation to decriminalization. Apart from the merits of this approach–to be discussed at length in this chapter – it is clear that tinkering with the criminal legislation is not indicative of an authentic public policy. In this Committee's view, **a public policy on cannabis must be, first and foremost and essentially, a public health policy based on encouraging government and users to assume more responsibility.**

On a general level, the tendency to reduce drug issues to the legal framework fits neatly into the increasing juridicization of social relations, a situation in which legislation is the central, sometimes the only, tool of government policy. However, in the matter of illegal drugs, other factors are also at work.

On the one hand, this attitude has been at the very heart of the approaches to drugs throughout the twentieth century, approaches in which criminal prohibition guides - and restricts - public policy. It is only because of the AIDS crisis that the merits of harm-reduction approaches have been "discovered." Even then, decision-makers were often preoccupied more with protecting non-user members of society than with improving the health of drug users. When governments decided to tackle the criminal behaviour of drug users deriving from the criminalization of drugs (we do not mean organized crime and drug traffickers), the aim was not so much to improve drug users' living conditions but to protect non-users from drug-related "mischief."

On the other hand, criminal prohibition is often thought of as the "ultimate stronghold" against uncontrolled proliferation of drug use. Without criminal prohibition, we were told, cannabis consumption might well explode out of control. The underlying hypothesis, rarely stated explicitly, that criminalizing drugs contributes effectively to reducing their use, has never been demonstrated, however. Quite the

contrary, as this chapter will show, available data tend to demonstrate that prohibitionist policies have little impact on levels of use or availability of drugs.

Public policy cannot be reduced to adopting legislation, the more so since laws rarely contain clearly stated guiding principles setting out aims and objectives. In respect of illegal drugs, where the key issues are, first and foremost, matters of public health and culture (including education and research), and where criminal law should be used only as a last resort, public policy must be based primarily on clear principles and objectives. For this to come about, public policy must be equipped with a set of tools designed to deal with the various issues that drugs represent to societies. Legislation is only one such tool.

The social and economic costs of illegal drugs affect many aspects of society through lower productivity and business loss, hours of hospitalization and medical treatment of all kinds, police time and prison time, and broken or lost lives. Even if no one can pinpoint the exact figures, a portion of these costs arise, not from the substances themselves, but from the fact that they are criminalized. The drug most frequently associated with violence and criminal offences, including impaired driving, is in fact legal, alcohol.[1] Cannabis, the criminal organizations that control part of the production and distribution chain aside, neither leads to crime nor compromises safety. Even its social and health costs are relatively small compared to those of alcohol and tobacco. In fact, more than for any other illegal drug, we can safely state that **its criminalization is the principal source of social and economic costs**.

However, in spite of the fact that the principal social costs of drugs affect business, health and family, the emphasis on the legal debate tips the scales of public action in favour of law enforcement agencies. No one can deny that their work is necessary to ensure public order and peace and to fight organized crime. At the same time, over 90% of resources are spent on enforcing the law, the most visible actions with respect to drugs in the public sphere are police operations and court decisions and, at least in the case of cannabis, the law lags behind individual attitudes and opinions, thus creating a huge gap between needs and practice.

Most national strategies display a similar imbalance. The national strategies that appear to have the greatest chance of success, however, are those that strive to correct the imbalance. These strategies have introduced knowledge and observation tools, identified indicators of success with respect to their objectives, and established a veritable nerve centre for implementing and monitoring public policy. The law, criminal law especially, is put in its proper place, that of one method among many of reaching the defined objectives, not an aim in itself.

This chapter is divided into three sections. The first examines the effectiveness of legal measures for fighting drugs and shows that legal systems have little effect on consumption or supply. The second section describes the various components of a

---

[1] Please refer to the recent CCSA study: Permanen, K., et. al., *op. cit.*

public policy. The third considers the direction of criminal policy, and defines the main terms used: decriminalization, depenalization, diversion, legalization, and regulation.

INEFFECTIVENESS OF CRIMINAL POLICIES

Two key indicators are usually applied to measure the effectiveness of drug-related criminal policy: reduced demand and reduced supply. Some authors attempt to measure the economic efficiency of various control options[2]; we do not address this aspect as the data are incomplete.

The methods of measuring the impact of public policy on supply and demand are faced with a series of methodological pitfalls. Firstly, the two indicators are relatively artificial and not easily distinguished from one another. In other words, a given measure impacts both indicators simultaneously and are often accomplished by the same institution For example, a police officer conducting drug "education" in schools, theoretically for the purpose of affecting demand, also works to reduce supply. Secondly, the capacity of agencies responsible for affecting one or the other depends on a series of factors relating to their means and resources, their practices and skills, and their competence. For the police, the number of officers per capita and the general thrust of law enforcement services (community police, traditional more reactive police) as well as the priority given to drug-related offences, can influence the volume of reported incidents as well as the decision to lay a charge. Generally speaking, the total resources allocated by a government to its drug policy may affect one or both of these indicators. In short, effectiveness cannot be measured directly.

It is even more difficult to assess, even indirectly, the impact of action taken, when clear objectives, ideally associated with indicators, are not defined, as is the case in Canada at this time, as was seen in Chapter 11. This being the case, and because we are in no position to make a rigorous assessment of public policy on drugs, we will examine the question on the basis of a series of indirect indicators.

Impact on consumption

General policy direction

At the most general level, national governments (see preceding chapter) define a general direction for their policies on drugs. Some are more tolerant or permissive (e.g., the Netherlands, Belgium, Spain, and Germany); others stress prohibition and abstention (e.g., the United States, Sweden, France). Admittedly, these are crude

---

2 See Jackson, A.Y. (2002) *op. cit.*, and our discussion in Chapter 18.

categories, ignoring the complexity of each country's policy. Even in the U.S.A. with its "war on drugs", individual cities and states may implement widely different measures. Furthermore, there is often a huge gap between public policy statement and concrete action. For example, in France, a tough stance on use is accompanied by limited user-related police activity. In Canada, as a number of witnesses told us, enforcement by police is often at odds with "lenient" court decisions. In other words, there is no direct relationship between political statements and concrete action.

Some comparative studies have attempted to determine whether or not public policy influences use levels. A study by Reuband compares "tolerant" European countries (the Netherlands, Spain, Denmark, and Italy) and restrictive countries (Germany, France, Norway, United Kingdom, and Sweden). The study found no significant differences between consumption levels, regardless of public policy direction.[3]

The "Message" of the *Conseil fédéral suisse sur la révision de la loi sur les stupéfiants* reports the results of a comparative study on seven European countries by Cesoni, which reached the conclusion that the legal regime had no influence on the frequency of consumption.[4]

Another study carried out for the *Office fédéral suisse de la Santé publique* classifies the policies of European countries on a line from "very liberal" to "very restrictive", relating them to the lifetime prevalence of cannabis consumption. The study shows no relation between severity of legislation and level of use.[5]

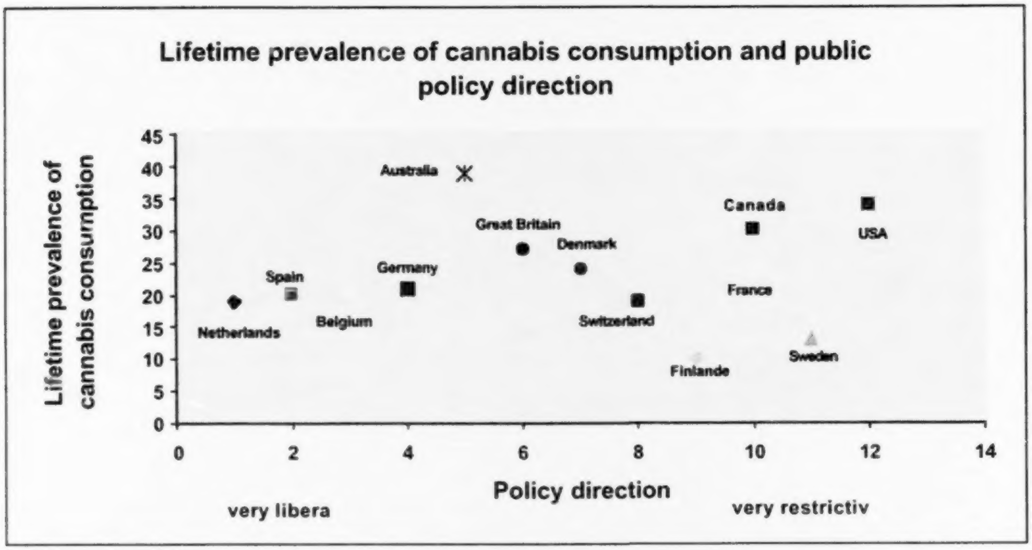
We have drawn up two similar charts, classifying the policies of the various countries and adding Canada, Australia, and the United States. We used the Chapter 6 data on lifetime prevalence of consumption in the general population (Chart 1) and in the past month among 15-16 year olds (Chart 2).

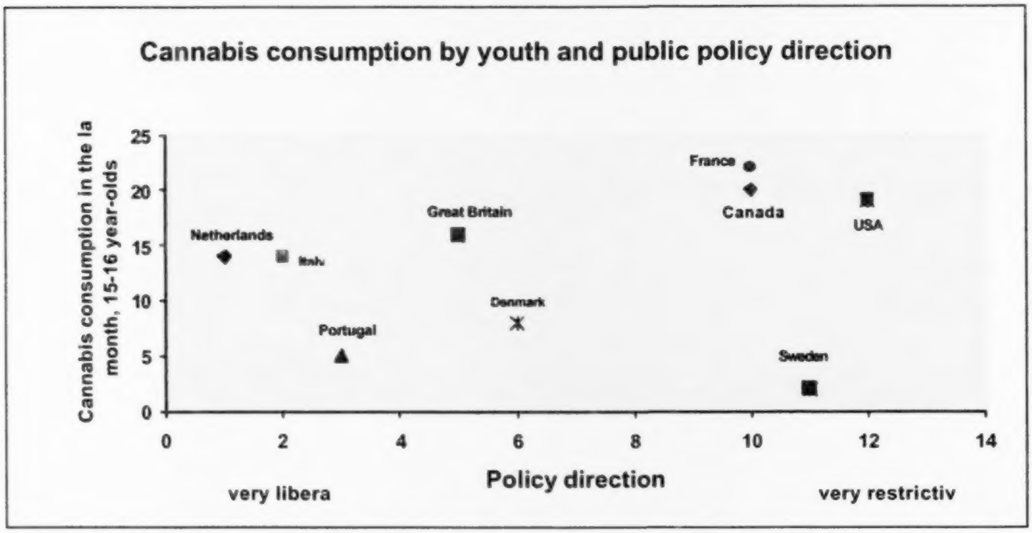
---

[3] Reuband, K., (1995) "Drug use and drug policy in Western Europe." *European Addiction Research*, vol. 1, 32-41.

[4] Cesoni, L.L. (1999) *Usage et actes préparatoires de l'usage des drogues illicites : les choix en matière d'ncrimination. Analyse comparative de l'usage de drogues illicites de sept législations européennes. In Conseil fédéral suisse*, op.cit., page 3560.

[5] *Conseil fédéral Suisse* (2001) *Message concernant la révision de la loi sur les stupéfiants*, page 3560.

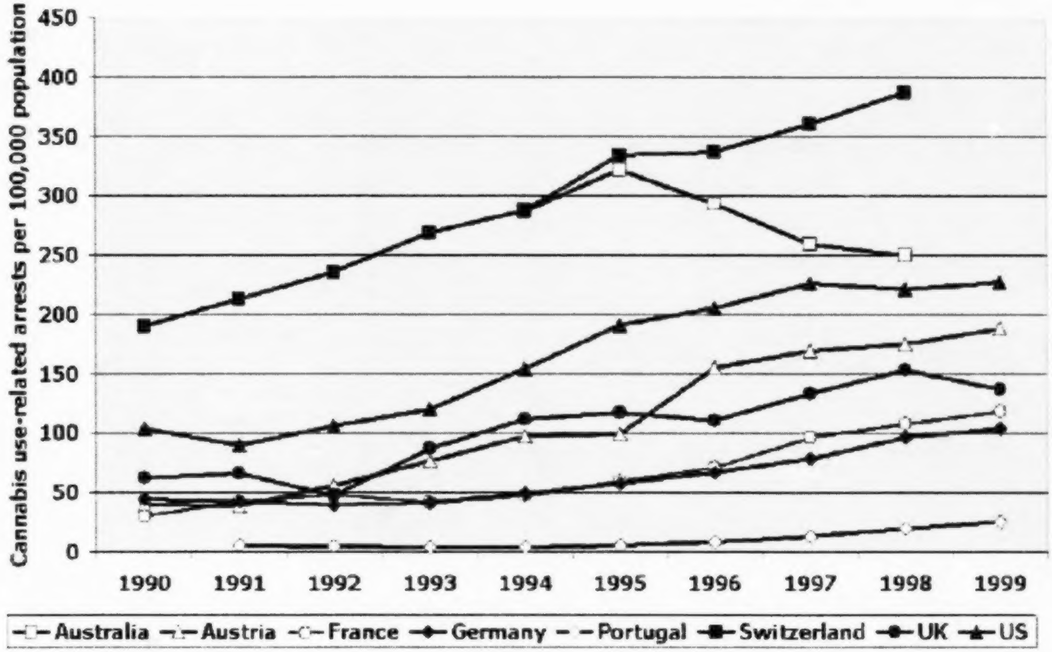




The charts show no direct relationship between consumption levels and public policy direction. Very liberal countries show low rates (Spain, the Netherlands, Portugal), whereas countries that have very restrictive policies show high rates (USA, Canada, France). Of course this may be explained by the fact that these are static statistical data not a time series, and are thus little influenced by variations from year to year. Another possible explanation is that, as few users are arrested, there is a strong inconsistency between words and action. The following section looks at this issue.

Cannabis consumption and arrests

A number of authors have looked at the relationship between arrest levels and delinquent behaviour in general, and in drug consumption in particular. One recent study was conducted by Kilmer[6] within the context of the International Scientific Conference on Cannabis. The following graph is from that study.



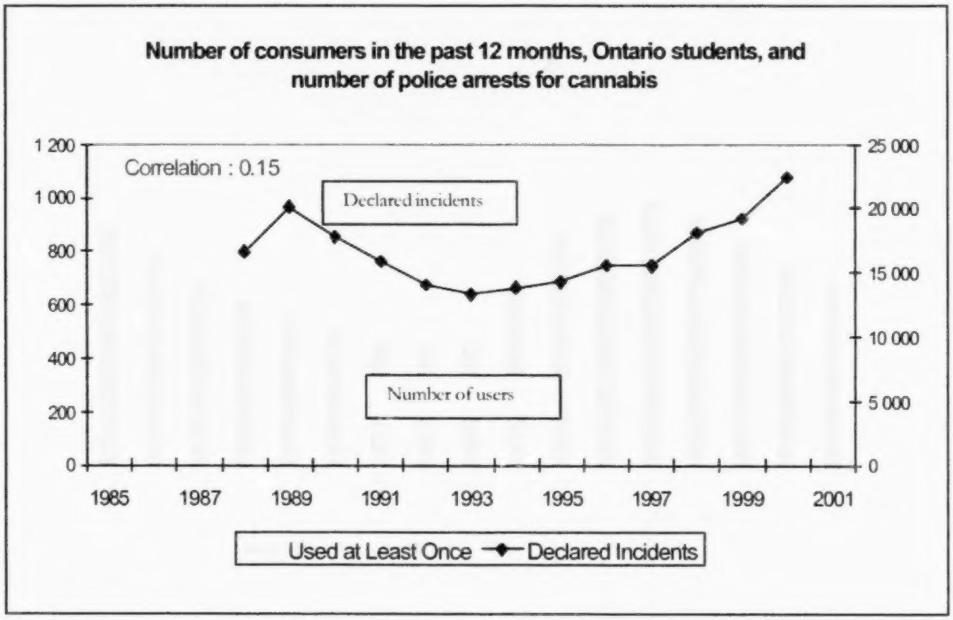
The graph shows that, in all countries, the number of arrests per inhabitant for simple possession of cannabis increased during the 1990s, with Australia the only exception. Switzerland, currently considered relatively moderate, has the highest level of arrests per inhabitant, followed by the USA, Austria, the United Kingdom, France, and Germany.

Here again there appears to be no direct relationship between direction of public policy and arrests. Switzerland and Australia, both of which have far more moderate policies than the USA, arrest proportionally larger numbers of people than that country, although Switzerland's consumption rate is far lower than that of the USA, and Australia's is virtually the same.

[6] Kilmer, B., (2002) "Do cannabis possession laws influence cannabis use?" in Pelc, I. (dir.) International Scientific Conference on Cannabis. Brussels.

The variation in rates of arrest cannot be explained by the number of police officers per inhabitant. France has far more officers than does the USA or England, but arrests far fewer people than the USA and fewer than the UK for simple possession.

We created a graph charting the relationship between the number of users among high school youth in Ontario in the past twelve months and incidents declared by the police of cannabis-related offences in the same year in Ontario. We chose Ontario because it is the only province that produces continuous time series on consumption levels, and the Ontario figures are almost identical to the Canadian mean (Chapter 14). The results are shown below.



The graph shows a very weak statistical relationship (0.15) between police activity and cannabis use. In other words, police activity has no dissuasive effect on cannabis experimentation by young students.

Criminology teaches that probability of arrest carries far more dissuasive weight than severity of sentence. As the following table shows, the probability of arrest is very low for cannabis possession offences.

Probability of being arrested for cannabis possession[7]

	1995	1996	1997	1998	1999
Germany			2.7%		
Australia	3.7%			2.1%	
Austria	1.7%		1.7%		2.0%
Canada	1.8%				
United States	2.8%	3.0%	3.1%	3.2%	3.2%
France					2.0%
United Kingdom		2.1%			
Sweden			2.4%	2.9%	

Public spending

While none of the preceding factors appears related to consumption levels, can a case be made for public spending?

There is danger in trying to estimate the overall cost of public policy on drugs. Even for a budget item as seemingly well-defined as law enforcement, estimates are unreliable. As we saw in Chapter 14, the cost of law enforcement ranges from $700 million to $1 billion. Figures on public expenditure related to treatment and prevention, even if we know that they are much smaller than those for law enforcement, are equally unreliable.[8]

Making international comparisons is even riskier. Services are organized differently, costs are not accounted for in the same way, and service orientation and overall government direction vary widely.

With these reservations, we will attempt the exercise based on data from a number of sources. To make the results a little more comparable, we restrict the comparison to law enforcement expenditures which, in any case, account for between 70% and 90% of public spending relating to illegal drugs. The following table summarizes the data. (Note that, for Canada, we have used the data from the CCSA study rather than our own estimates from Chapter 14. Our data show a cost estimate of law enforcement (police, courts, prisons) of approximately $1.5 billion or $50 per capita).

[7] Table reproduced from Kilmer, B., *op.cit.* page 108.

[8] See Kopp, P. and Fenoglio (2000) *Le coûts social des drogues licites (alcool et tabac) et illicites en France.* Paris: OFDT.

Costs of enforcing legislation in various countries

	Cost of enforcing legislation	Per capita costs
Germany, 1992 [9]	DM 6.3 billion	
Australia, 1992 [10]	A$450 million	
Canada, 1992 [11]	US$300 million	US$10
United States [12]	US$12.3 billion	US$40
France, 1998 [13]	US$500 million	US$8
The Netherlands [14]	US$230 million	US$15

We note that countries in which consumption levels are average (Germany, the Netherlands) spend less than the USA, which has a high consumption rate; in addition, these countries, specifically, show law enforcement expenditures above those of two far more restrictive countries (France and Canada).

In short, here again cannabis consumption levels appear unaffected by public policy that aims to reduce demand by cracking down on use.

Impact on supply

Does public policy affect drug availability or price? The available data suggest not.

In spite of sustained efforts to exert national and international control, battle drug trafficking (macro and micro, local and international), the availability of drugs, and cannabis in particular, has not fallen. Price has fallen significantly (e.g., heroin, cocaine) or remained relatively stable (e.g., cannabis and derivatives).[15] The relative price increase for some grades of cannabis is at least as closely linked to attempts to improve

[9] Source: Rehm, J., (2001) *The Costs of public policies to fight illegal drugs.* Brief presented to the Special Senate Committee on Illegal Drugs, page 13.

[10] Source: Rehm, J., (2001) *The Costs of public policies to fight illegal drugs.* Brief presented to the Special Senate Committee on Illegal Drugs, page 13.

[11] Single, E., et. al., *op. cit.*

[12] Source: Kopp, P. and C. Palle (1999) *"Économistes cherchent politique publique efficace."* in Faugeron, C., (ed.) *Les drogues en France.* Paris: Georg, page 261.

[13] Source: Kopp, P. and C. Palle (1999) *"Économistes cherchent politique publique efficace."* in Faugeron, C., (ed.) *Les drogues en France.* Paris: Georg, page 261.

[14] Source: Kopp, P. and C. Palle (1999) *"Économistes cherchent politique publique efficace."* in Faugeron, C., (ed.) *Les drogues en France.* Paris: Georg, page 261.

[15] See above, in the United States, one of the most complete studies on the question: Abt Associates (2001) *The price of illicit drugs: 1981 through the second quarter of 2000.* Washington, DC: Office of National Drug Control Policy.

"quality" (e.g., THC content, organic cultivation) and the large profit margin earned by producers and traffickers, as it is to the efforts of law enforcement agencies.

Conclusion

The title of this section includes our conclusion: **if the aim of public policy is to diminish consumption and supply of drugs, specifically cannabis, all signs indicate complete failure. We agree with the conclusions from the Swiss studies that prohibiting cannabis use through the application of criminal law appears to have little, if any, influence on levels of use.**

One may think the situation would be worse if not for current anti-drug action. This may be so. Conversely, one may also think that the negative impact of anti-drug programs that are currently centre stage are greater than the positive effect, specifically non-compliance with laws inconsistent with majority attitudes and behaviour.

One of the reasons for this failure is the excessive emphasis placed on criminal law in a context where prohibition of use and a drug-free society appear to remain the omnipresent and determining direction of current public policies.

Does this mean nothing can be done? We do not believe so. Does it mean market forces should be allowed to rule as if drugs were goods like any other commodity, a solution suggested by some free-market advocates?[16] Certainly not. Psychoactive substances, including cannabis, alcohol, and medications, are not ordinary commodities. Although cannabis (see Chapter 7) does not have the deleterious effects that some people claim and is in some respects a less harmful substance than tobacco, it must be the subject of regulation and government intervention.

The question raised by the patent and costly failure in human, social, and economic terms of Canada's public policy direction to date, is what should be the direction and components of public policy on cannabis and, as a corollary, the role and direction of legislation. This is what is discussed in the following sections.

GENERAL ECONOMY OF A PUBLIC POLICY ON CANNABIS

We are fully aware of the somewhat artificial distinction imposed by our mandate between cannabis and its derivatives and other psychoactive substances. Different substances lead to different types of uses. This is as true of cannabis as it is of alcohol, medications, cocaine, or ecstasy. The uses differ with the substance - cannabis consumption differs from consumption of medications or even alcohol. There is nonetheless a common basis to the non-medical uses of psychoactive substances, which are primarily seen as a source of pleasure, even a method of enhancing awareness and the senses. There are of course other forms of use: abuse, for example, is not based

[16] For example, economist Milton Friedman.

on pleasure but rather a physiological and psychological mechanism symptomatic of loss of control, even distress. Nevertheless, throughout history human beings have consumed psychoactive substances for reasons relating to self-liberation.

Uses also differ for a given substance. Cannabis use, originally associated with self-medication and religious rites, in twentieth century western societies became an expression of a counter culture and the hippie movement, before becoming a recreational drug. Although most cannabis use is self-regulated, in some cases, when associated with at-risk behaviour, use can lead to abuse.

For public policy on psychoactive substances to adequately encompass the common dimensions of substance use, it must be **integrated**, yet flexible enough to allow for **approaches that are adapted** to different substances.

An integrated public policy on drugs would be administered by a decision-making body capable of making links between the substances and their uses so as to propose a meaning to different drug uses. A public policy on drugs revolves around the varying uses made of drugs and not on the substances themselves. In other words, an approach more like that taken by France's *Mission interministérielle* instead of an approach by multiple decision-making bodies, each one operating in a functional silo, in competition with the others as in the States, or for that matter in Canada, where illegal drugs, tobacco and alcohol are handled by different agencies.

An adaptable policy would be able to propose, define and develop tools suited to the various substances. Abuse of cigarettes causes lung cancer, not death due to impaired driving. Some medications, however, do lead to fatal accidents. Cannabis may be associated with both problems: cancer related to combustion, and highway accidents related to psychomotor effects. We must be in the position to understand what is specific to a given substance and what is common to a variety of substances.

A public policy, both integrated and adaptable must aim for knowledge of the relationship between substances and methods and contexts of use, in order to define the determining factors that separate non-problematic self-regulated consumption, from at-risk behaviour, and excessive use and related problems. There are two broad types of problems: the first affect user health, the second the health and safety of others; they must be dealt with in different ways. Certain measures must be preventive - inform users of risks and, specifically, help individuals recognize the signs of at-risk behaviour that can lead to problems. Those who consistently smoke between three and five cigarettes a day, something very few tobacco consumers may be able to do, are probably at no greater risk of lung cancer than non-smokers. Learning to manage consumption, recognizing the dangers, and having the means and the tools to do so are key. Other methods are dissuasive in nature: where drinking and driving are involved for example. Finally, some measures are curative: whatever the substance, from simple aspirin to heroin, for all kinds of reasons that pre-date consumption of the substance itself, some individuals consume abusively in a way that leads to health problems. The tools for treatment and cure must be available.

Thus, and this is the third criterion, a public policy on psychoactive substances must primarily be a **public health policy**: prevention, abuse deterrence, and treatment are the three prongs of public health intervention. A public health policy does not attempt to oblige people to live healthy lives or to have the community decide individual behaviour for some elusive public good. What we envision is a public health policy that contributes to **reducing the risks relating** to the different uses of different substances. A public health policy on psychoactive substances is thus a risk reduction policy.

Harm reduction approaches have been associated with needle exchange or the prescription of methadone or heroin. Some think that harm reduction policies rely too heavily on a medical model, simply softening the negative effects of an otherwise prohibitionist regime.[17] Harm reduction has been described as a "*transition doctrine, contradictory and ambiguous, with the ambiguity enabling unlimited adaption.*" [Translation][18] Even worse, according to American psychiatrist Thomas Szasz, it is a morally repugnant position reflecting government therapeutic paternalism.[19]

We believe that what is essential is recognition that (1) use of psychoactive substances cannot be eliminated, it is part of the human experience and not all use is abuse - whatever the substance - and (2) all substances can have negative consequences for both the user and society, making it advisable to contribute to individual and community well-being by providing information, abuse prevention tools and a treatment infrastructure. Recognition that an individual is no less a citizen, indeed no less a good citizen, because he chooses to smoke cannabis rather than drink alcohol, or chooses to use rather than abstain, but that individuals and societies, according to the circumstances and method of consumption, will have different needs is the key .

A public policy on drugs does not target users: its implementation embraces them. For too long, in any discussion of illegal drugs, including cannabis, the focus has been on understanding the characteristics specific to consumers, as if they had some feature distinguishing them fundamentally from users of tobacco, alcohol, or psychotropic medications for non-medical use. Although problem users may indeed have common characteristics, it is neither the substance nor being a user that is the question: other factors underlying development of at-risk behaviour should be given more attention.

Some people told us that harm and risk reduction policies, or for that matter decriminalizing cannabis, would "trivialize" its use. On the contrary, this is normalization, not trivialization. Excessive use of any substance is harmful: all substances may endanger user health, even coffee. Normalizing the use and the user does not mean trivializing them. A public policy on drugs aims to **normalize uses of psychoactive substances:** that implies not marginalizing users, while at the same time

---

[17] For example, critical assessment in Caballero and Bisiou, pages 114-115.

[18] *Ibid.*, page *116.*

[19] *Ibid.*, page 120

not trivializing use and shrugging our shoulders, ignoring the dangers specific to various substances.

To summarize: a **public policy on psychoactive substances must be both integrated and adaptable, target at-risk uses and behaviours and abuses taking a public health approach that neither trivializes nor marginalizes users**. Implementation of such a policy must be multifaceted, as we will see now.

COMPONENTS OF A PUBLIC POLICY

The public policies described in the preceding chapter, as well as the policies of Denmark, Portugal, and Mexico, have a number of elements in common: they rely on a strong decision-making body, promote interconnection and multiple viewpoints, aim at national consensus on clear and measurable objectives, and rely on independent knowledge and assessment tools.

Strong decision-making body

One may disagree with the political orientation of the American Office of National Drug Control Policy (ONDCP); but no one can deny the office gives strong direction to American national policy on drugs. Although one may be critical of the structural rigidity of the French *Mission interministérielle* (MILDT), or its timidity with respect to legislative debate, however, one cannot help but agree that the MILDT has strongly influenced French policy and practice in the past five years. Each country covered in the preceding chapter has a highly visible, well-known decision-making body that has undeniable legitimacy and methods of action that meet expectations.

In our opinion, the question of drugs, inasmuch as it is broader than the jurisdiction of a single government department or level of government, inasmuch as it refers to our collective ways of relating to society and others, and especially inasmuch as it demands both integration and differentiation, must be governed by an agency that is not accountable to a particular department and can define direction for (not enforce diktats on) all players.

Interconnection

The policies on psychoactive substances are the concern of educators and therapists, police officers and anthropologists, diplomats and local associations and, of course, users. The ability to tie things together for knowledge and comprehension purposes supposes an ability to link specialties, administrations, individuals. This is the meaning of interconnection that a public policy must be capable of making.

A shared definition of shared objectives

In Chapters 11 and 18, we saw that federal policy on drugs, in addition to lacking rigour and clarity, means and infrastructures, is not a national policy. This does not mean there is no place for specific approaches by the provinces and territories that make up the Canadian mosaic. However, if a common culture on drugs is to emerge, if we are to better understand behaviours of use through geographic comparison, if players are to benefit from the experience of others, tools must be developed for the joint definition of shared objectives.

Moreover, the ability - and the will - to define objectives is the foundation of any future evaluation to determine whether or not the action taken is in sync with the objectives and is effective; in short, defining objectives is necessary because we must be able to assess the impact of what we do.

Information tools

A public policy must also rest on knowledge. Many witnesses, from all over, told us this. European Union member countries, the United States and Australia have developed powerful knowledge tools, specifically agencies that monitor drugs and drug addictions. These monitoring agencies, most of them independent of the government and political influence, are capable of measuring changing trends and forms of use of various substances, understanding emerging trends and new products, even assessing public policies. We are unable to see how Canada can fail to develop a national knowledge tool on psychoactive substance use.

LEGISLATIVE OPTIONS

So what do we do with the legislation? Legislation stems from public policy direction, which it supports and completes; it is a means, not an end.

Cannabis debates are highly contaminated by discussions on decriminalization, depenalization, legalization. The terms are frequently poorly understood, especially as they are not necessarily clear. This section defines each key term in the debate and suggests indicators that can be used to assess each option.

Clarification of terminology

Decriminalization or depenalization

The United Nations Drug Control Programme (UNDCP) glossary of terms on drugs gives the following definitions of the two terms.

> ***Decriminalization or depenalization***
> *Removal of penal controls and criminal sanctions in relation to an activity, which however remains prohibited and subject to non-penal regulations and sanctions (e.g., administrative sanctions such as the removal of driving licence).*
> *Under the "prohibition with civil penalties" option, the penalties for the possession of amounts of drugs deemed in law as being for personal use are still illegal but are dealt with by civil sanctions such as infringement notices which attract a monetary penalty, rather than by criminal sanctions such as a criminal record or imprisonment. Typically, the harsher criminal penalties still apply to the more serious offences of possession, supply, manufacture or cultivation of amounts of the drug deemed in law to be for trafficking or commercial purposes.*[20]

For Caballero and Bisiou, depenalization means essentially removing drugs from the field of criminal law. They distinguish between total depenalization and depenalization of use.[21] The first removes all control except free-market forces. This is a far cry from the UNDCP definition. Depenalization of use corresponds more closely to decriminalization as defined by UNDCP. It is also the definition given by the European Monitoring Centre for Drugs and Drug Addiction.

Possessing or holding cannabis for personal use has been decriminalized in Germany, Australia, Spain, Italy, Portugal, the Netherlands, and some American states. The resemblance ends there because each country has slightly different way of reaching the goal. In Australia and the American states where possession of cannabis has been decriminalized, possession remains illegal and subject to a fine. In Germany, the constitutional court has ruled that prosecution for possession of small quantities of cannabis contravenes basic rights and is unjustified. In Spain and Italy, possession of small amounts of cannabis is not an offence and consumption is authorized except in public places. However, as in Portugal, individual possession of cannabis is subject to an administrative penalty (fine in Spain and Portugal; suspended licence in Italy).[22] In the Netherlands, the possession offence has never been repealed, although use and certain types of sale (coffee shops) are tolerated.

In all cases, decriminalization is partial. It is sometimes *de jure* (Spain, Italy, Portugal) and sometimes *de facto* (the Netherlands, Denmark).

---

[20] UN Office for Drug Control and Crime Prevention (2000) *Demand Reduction. A Glossary of Terms.* Vienna: author, page 18.

[21] Caballero and Bisiou, *op.cit*, page 117.

[22] See EMCDDA (2001) *Decriminalisation in Europe? Recent Developments in Legal Approaches to Drug Use.* Lisbon: author, available on line at www.emcdda.org

In Canada, some authors have written in favour of decriminalizing cannabis. One of the best known papers on this option may be that published by the policy committee of the Canadian Centre on Substance Abuse.[23] The authors identify four options for decriminalization:

- Fines under the *Controlled Drugs and Substances Act* (CDSA) excluding incarceration as a possible sanction. The option retains the illegality of cannabis possession and related criminal record consequences.
- Civil offence: here again the sanction is a fine, although the option differs from the first in that cannabis possession is no longer sanctioned under the CDSA, but subject to a sanction under the *Contraventions Act.*
- Alternative measures (or diversion): under this option, possession remains a punishable criminal offence, but sanctions are suspended if the offender agrees to another form of "treatment" or community service. Drug treatment courts are a form of alternative measure.
- Transfer to the provinces: under this approach, the provinces would be free to adopt the control measures they deem necessary (with the exception of criminal measures which are exclusively federal). However, it is difficult to understand the reasoning of the authors on this approach as it is more a form of legalization than decriminalization.

In Quebec, the *Comité permanent de lutte à la toxicomanie (*CPLT*)* has made a recommendation proposing diversion measures when deemed appropriate by the authorities.[24] The CPLT defines diversion as the "*exercise, by the Crown prosecutor, of a discretionary power enabling him to desist from prosecuting the offender and instead apply alternate measures*" [Translation].[25] However, diversion may be given a broader definition, in which the discretionary power is exercised by the police prior to a charge, giving a consumer a simple warning. The CPLT opinion notes the following.

- Cannabis related offences account for at least 60% of offences under the CDSA, with possession the most frequent.
- The number of offences for possession of cannabis is rising, whereas the proportion that lead to prosecution is falling, even though such prosecution remains in a majority (approximately 60% of 1997 cases).
- The practice of laying charges and applying alternative measures varies among regions of Canada and within Quebec.
- Most sentences handed down by the courts are fines.

---

[23] Fischer et al., (1998) "Cannabis Use in Canada: Policy Options For Control.' *Policy Options.* October.
[24] *Comité permanent de lutte à la toxicomanie* (1999) *Avis sur la déjudiciarisation de la possession simple de cannabis.* Montreal: CPLT.
[25] *Ibid.*, page 2.

This timid recommendation refuses to take a systematic approach and even links cannabis consumption to delinquent or criminal activities, relating risk to consumption of products with a high THC concentration, as if consuming spirits should be subject to stronger measures than drinking wine.

The term "decriminalization" is obviously loaded with contradictions. Even though the term purports to remove it from the ambit of criminal law, cannabis consumption remains illegal. The sanction may be less severe, but a sanction still applies, one that, in some cases, can have the same impact as a criminal sanction and entail even greater discrimination: a young or disadvantaged person unable to pay the fine faces a far greater risk of ending up in prison than an adult or socially secure individual. As explained to the Committee by Dr. Kendall:

> *However, a cautionary note should be sounded. If Canada did adopt this recommendation, we should be concerned and thus take steps to avoid the situation in Australia, or to repeat that situation, where the imposition of a cannabis expiation program actually led to a net widening effect, because the police now ticketed individuals that they had previously ignored. Many of those so ticketed failed to appear to pay their fines, and subsequent numbers entered the criminal justice system for non-payment of fines and subsequently received criminal convictions. There was an unintended result in that the number of persons criminalized is as large, or perhaps larger, than before the measure was implemented.* [26]

In spite of its merits and success, the Dutch system of controlled cannabis sale, a form of *de facto* decriminalization, has no way of regulating production and distribution, which is still controlled at least in part by organized crime, or exercising quality control, specifically the concentration of THC.

In the opinion of some authors, decriminalization is in fact simply less severe prohibition.[27] In other words, in the guise of a socially responsible and rational measure, decriminalization in fact furthers a prohibitionist logic. Same grounds, different form. This model has no greater capacity for prevention or education than a strict prohibition model. Even worse, the prohibition model is based on clear and consistent theory, whereas the same cannot be said of decriminalization as an approach.

Some will say that decriminalization is a step in the right direction, one that gives society time to become accustomed to cannabis, to convince opponents that chaos will not result, to adopt effective preventive measures. We believe however that **this approach is in fact the worst-case scenario, depriving the State of a regulatory tool needed in dealing with the entire production, distribution, and consumption network, and delivering a rather hypocritical message at the same time.**

---

[26] Dr. Perry Kendall, Medical Health Officer for the Government of British Columbia, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First session, Thirty-seventh Parliament, September 17, 2001, Issue 6, page: 40.

[27] MacCoun, R., Reuter, P. and T. Schelling (1996) "Assessing alternative drug control regimes." *Journal of Policy Analysis and Management.* Vol 15, no 3, page 332.

Legalization

The United Nations glossary of terms defines this term as follows.

Legalization

Removal of the prohibition over a previously illicit activity, e.g., non-medical trade or consumption of psychoactive substances. It does not necessarily imply the removal of all controls over such activity (e.g. restriction on sale to minors). [28]

The term "legalization" is equivalent to Caballero and Bisiou's concept of depenalization, although it does not rely solely on market forces but includes a form of regulation entailing some restrictions. To quote:

Controlled legalization is a system that aims to replace existing prohibition of drugs by regulation of their production, trade, and use with a view to restricting abuse that can damage society (...) unlike depenalization, penal law retains its role in preventing damage to third parties by users (drunkenness) or producers (contraband). [Translation] [29]

No system for controlled legalization of cannabis currently exists. Switzerland comes close with its bill to amend the *Loi sur les stupéfiants*. This type of regulation is nothing new: colonial opium and kif regulatory bodies operated well into the first half of the twentieth century.

Conversely, legalized systems exist for the manufacture, distribution, sale and production of such products as alcohol, tobacco, and psychotropic medications. These could be used as a model for regulating the cannabis production chain.

Regulation

The United Nations glossary of terms defines regulation as follows:

Regulation

The rules governing all aspects of drug control promulgated pursuant to legislation. Violation of these rules may attract criminal or non-criminal penalties, such as fines and license suspension, depending on the seriousness and the intentional nature of the violation. [30]

Although one may play with words, regulation is in fact a necessary application of any form of control, whether within a system of prohibition or a system of legalisation. All consumer products, from the automobiles we drive to the food we eat, are subject to some form of regulation. Quality control, environmental standards, compliance with industrial standards, regulations on accessibility—all are forms of regulation essential

[28] UNDCP (2000) *op.cit*, page 41.

[29] Caballero and Bisiou, *op.cit*, page 132.

[30] UNDCP (2000) *op.cit*, page 63

for ensuring no one is poisoned by the food they eat, drives a defective vehicle, or plugs in a dangerous appliance.

Regulation is the most current form of government control; criminal law usually intervenes when the controls fail or mandatory standards are not met.

The same is true of the current international system for controlling narcotics. Canadian legislation deals with "controlled" substances. The control system may range from prohibition of all non-medical and non-scientific use (e.g., opium, cocaine, cannabis), to less severe control measures that allow accessibility to products deemed dangerous, under specific conditions.

Classification of legal policy systems

MacCoun, Reuter and Schilling examine various systems of legal policy, which they divide into three main types: prohibitionist, controlled access, and regulated access, each of which can be broken down further. Their classification system is reproduced below.[31]

Prohibitionist systems vary along a number of lines: based on the nature of prohibited activity (e.g., possession, use, use in public); based on the severity of sanctions (civil penalty, criminal penalty, imprisonment); based on the severity of enforcement (resources, priorities); and based on the capacity to exercise discretionary power (diversion, alternative measures). This makes it clearer why decriminalization remains in essence a prohibitionist approach, albeit a less severe one.

Controlled access systems are in a grey area somewhere between prohibition and regulation. In some ways, they are more like prohibition models, particularly by giving powers of decision to a physician or pharmacist rather than promoting individual user responsibility. This is the medical model criticized by Szasz, Caballero and, closer to home, Malherbe, in his discussion paper on the role of ethics and public health. One can see why harm reduction approaches belong in this grey area, somewhere between prohibition and regulation, with the prescription of methadone or heroine for treating addiction the perfect example of medical power.

The third type is the regulatory model that exercises various types of control on who (who may purchase, restrictions on minors), what (different accessibility levels for different substances), how (point of sale, location, requirement for producers and vendors) and when (time of day, days of the week).

[31] MacCoun and coll., *op. cit.* page 333. [1996 issue vol.15 not available]

Prohibitionnist		Pure prohibition : no use possible (i.e., cannabis)	Decreasing restriction
	Controlled access	Prohibitionist prescription : medical and scientific purposes only	
		Treatment : prescription for the treatment of dependency (i.e., methadone)	
	Regulatory	Regulated prescription : auto administration under prescription to treat medical conditions (i.e, Valium)	
		Positive licensing : available to any adult with a licence to demonstrate his capacity to make responsible use	
		Negative licensing : accessible to any adult who has not violated some condition (i.e., criminal behaviour)	
		Free market for adults : similar to alcohol	
		Free market : no regulation (i.e., coffee).	

In our opinion, **there are basically only two systems:** a prohibition system and a legalization system. Both rest on regulation, and the nature and direction of this regulation determines their specific features.

Prohibitionist systems may be subdivided into criminal and medical prohibition. In the first case, sometimes referred to as outright prohibition, the justice system (police and the courts) is central. In the second, the physician is the key player. In both cases, the user is considered a "minor", a person in danger who must be protected from himself. Some call this legal paternalism. Both variations can be more or less strict, more or less severe, but rest on the concept that all use that poses a danger to the user and society and must be strictly controlled. In this scenario, **decriminalization of use is a weak variation of prohibition**, in the long run entailing more disadvantages than advantages. In addition to failing to affect the production chain and retaining the illegal aspect, it leaves no room for dispensing information to and promoting responsible behaviour by users, or for strong preventive measures. Conversely, **the harm**

reduction approach is a strong variation of a prohibition system. While this approach recognizes the impossibility of eliminating the damage done by market criminalization, it seeks nonetheless to reduce the negative effects of prohibition on users, who are the focus of its main thrust, by introducing education on drug content (for example, analysis of ecstasy consumed at raves).

Prohibition System

	Main player	Degree of prohibition	Severity
Criminal	Police / Justice	Prohibition of fabrication, cultivation, production, sale, trafficking, use and consumption	↓
		Decriminalization of use with criminal process / diversion	
		Civil offences	
Medical	Physician	Recognized therapeutic uses only	
		Treatment for dependency	
		General prescription by a physician	↓

A prohibition system, whether criminal or medical, calls for regulation derived from criminal law: any interaction with drugs that is not authorized under the medical model is punished by a criminal or quasi-criminal penalty.

The other type of system rests on legalization of cannabis. It can also take various forms.

Legalization System

	Main player	Accessibility level	Degree of control
State	Community	User licences	+
		Licence for production / distribution / sale	↓
Market	User	Free market	-

Legalization systems range from issuing a user licence under certain conditions (e.g., no criminal record, no dependency problems), to permitting a completely uncontrolled free market.

Criteria for a legal policy on cannabis

Some studies have explored the question of the comparative effectiveness of public policy systems in cost/benefit terms, others in terms of social costs. The first type of analysis is impossible simply because no two strategies are different enough for purposes of comparison: there is no cannabis regulation model that can be compared to a prohibition model. The other approach is to consider the social costs incurred by drugs based on a "cost of illness" model in a "counter-factual" scenario: what would happen if there were no consumption of this drug? However, as we saw in Chapter 18, it is difficult to establish the real costs related to cannabis and the response of public policy to it, and impossible to determine real social costs.

> *The question is whether or not society would be better off if the use of one or more currently illegal drugs was authorized. The answer is only if public well-being is enhanced (or the social cost of drugs is reduced). No one knows the impact on social costs of legalization of illicit drugs. It is impossible to predict the impact of increased consumption, substitution of tobacco and alcohol for currently illegal drugs, the lower current negative impact attributable to drug illegality and, moreover, the combined impact of all these factors. The superiority of neither prohibition nor legalization is provable. [Translation]* [32]

The counter-factual scenario used in studies of the social costs of drugs is itself a formidable challenge, as it rests on the unproven concept of eradicating consumption of a drug. The model is drawn from the field of health, in which a counter-factual model may be legitimate because, in some cases, a disease can be completely or almost completely eradicated (e.g., childhood diseases). It does not apply to drugs, as the process is necessarily so hypothetical that one wonders if it is worth the effort. It is one thing to try and identify as accurately as possible the diversity of social and economic costs incurred by drugs and then reflect on public policy options; it is another to claim they can actually be measured.

MacCoun, Reuter, and Schelling propose two series of criteria, the first considering different applications to different substances, the second based on acceptable costs and consequences. Using a four-axis matrix, they distinguish:

- scope of consequences: community and user health; community and individual performance; public order and security;
- potential damage to each of the above;
- those affected by the damage (users, traffickers, family members, employers, neighbours, society); and

[32] Kopp, P., and P. Fenoglio (2000) *op.cit*, page 12.

- primary source of the damage (substance, legal status, legal intervention).

How do we make a choice? At the outset, it must be understood that, at the end of the line, the **decision is necessarily a political one**. Epidemiological data on levels of use and empirical data on effects and consequences are clear: cannabis is not as dangerous a substance as interdiction policies would like us to believe. Comparative data on public policies, although more limited, also make it clear that measures undertaken under prohibitionist regimes have not been effective. This much said, no one can predict what will happen under an alternative regime, such as the regulated access model we are proposing. This is why we insist that any comprehensive strategy on cannabis must be based on a public health model and involve tools to evaluate its implementation and effects.

Application to cannabis

We do not have all the empirical data required to make a decision with respect to all the potential consequences of different control systems. To produce such data, one would have to have experienced the different regimes of cannabis control. Since the early twentieth century, various degrees of prohibition are all there has been, however.

Be that as it may, we would hazard a guess that, even if we did have empirical data, in the final analysis the decisions would still be political in nature because they are basically public policy decisions which, as discussed in our chapter on guiding principles, are not defined on the basis of scientific knowledge alone.

Nonetheless, if we attempt to apply these criteria to cannabis, we believe that a **system of regulated access** is most likely to reduce the negative consequences for both users and society.

	Prohibition	Regulation
Consequences on:		
Health	- Use denied therefore no possible distinction between forms of use (use, at-risk use, abuse) - Difficulties adapting prevention to reality due to predominance of abstinence - Health costs due to lack of knowledge of forms of use - Absence of quality control may bring about problems - Difficult for users to recognize at-risk use and acknowledge possible dependency	- Possible increase in number of users - Enhanced recognition of use and ability to distinguish between forms of use - Ability to promote prevention not based on abstinence - Possible increase in health care for abusive users resulting from increase in number of users - Opportunity to control quality and THC content - Monitoring of at-risk behaviour and forms of non-penal treatment

Conduct of individuals and society	- Enhanced individual performance (e.g., school, professional) if prohibition totally successful and no substitute exists - Users potentially dealing with criminal networks - Human rights infringements - Theoretical decrease in availability of substance - Theoretical increase in price of substance	- Possibility of increased negative impact on users and their families if consumption increases - Legal access leading to normalizing and demystifying - Control over price and availability - Elimination of the negative consequences of criminalization and marginalization of users - Need to control impaired driving - Need to maintain restrictions regarding sale to minors
Public order and safety	- Increased organized crime - Significant illegal trafficking - Decreased respect for the law - Violence in criminal organizations	- Decrease in —not elimination of—organized crime - Increased control over illegal trafficking - Possible increase in the insecurity of people residing near points of sale

We are fully aware that our statements with respect to a regulatory system are wholly theoretical. We do think, however, that all the data we have collected on cannabis and its derivatives provide sufficient ground for our general conclusion that the **regulation of the production, distribution and consumption of cannabis, as part of an integrated and adaptable public policy, best responds to the principles of autonomy and governance that foster human responsibility and of the limitation of penal law to situations where there is demonstrable harm to others. A regulatory system for cannabis should permit, in particular, :**

- **more effective targeting of illegal traffic and a reduction in the role played by organized crime;**
- **prevention programs better adapted to the real world and better able to prevent and detect at-risk behaviour;**
- **enhanced monitoring of products, quality and properties;**
- **better user information and education;**
- **respect for individual and collective freedoms, and legislation more in tune with the behaviour of Canadians.**

In our opinion, Canadian society is ready for a responsible policy of cannabis regulation that honours these basic principles.

CONCLUSIONS AND RECOMMENDATIONS

The Senate Special Committee on Illegal Drugs' mandate was to examine Canada's public policy approach in relation to cannabis and assess its effectiveness and impact in light of the knowledge of the social and health-related effects of cannabis and the international context. Over the past two years, the Committee has heard from Canadian and foreign experts and reviewed an enormous amount of scientific research. The Committee has endeavoured to take the pulse of Canadian public opinion and attitudes and to consider the guiding principles that are likely to shape public policy on illegal drugs, particularly cannabis. Our report attempted to provide an update of the state of knowledge and of the key issues, and sets out a number of conclusions in each chapter.

This final section sets out the main conclusions that emerge from all this information and presents the resulting recommendations that derive from the thesis we have developed namely: ***in a free and democratic society, which recognizes fundamentally but not exclusively the rule of law as the source of normative rules and in which government must promote autonomy insofar as possible and therefore make only sparing use of the instruments of constraint, public policy on psychoactive substances must be structured around guiding principles respecting the life, health, security and rights and freedoms of individuals, who, naturally and legitimately, seek their own well-being and development and can recognize the presence, difference and equivalence of others.***

LE DAIN – ALREADY THIRTY YEARS AGO

Thirty years ago, the Le Dain Commission released its report on cannabis. This Commission had far greater resources than did we. However, we had the benefit of a much more highly developed knowledge base and of thirty years' historical perspective.

The Commission concluded that the criminalization of cannabis had no scientific basis. Thirty years later, we can confirm this conclusion and add that continued criminalization of cannabis remains unjustified based on scientific data on the danger it poses.

The Commission heard and considered the same arguments on the dangers of using cannabis: apathy, loss of interest and concentration, learning difficulties. A majority of the Commissioners concluded that these concerns, while unsubstantiated, warranted a restrictive policy. Thirty years later, we can assert that the studies done in the meantime have not confirmed the existence of the so-called amotivational syndrome and add that most studies rule out this syndrome as a consequence of the use of cannabis.

The Commission concluded that not enough was known about the long-term and excessive use of cannabis. We can assert that these types of use exist and may present some health risks; excessive use, however, is limited to a minority of users. Public policy, we would add, must provide ways to prevent and screen for at-risk behaviour, something our policies have yet to do.

The Commission concluded that the effects of long-term use of cannabis on brain function, while largely exaggerated, could affect adolescent development. We concur, but point out that the long-term effects of cannabis use appear reversible in most cases. We not also that adolescents who are excessive users or become long-term users are a tiny minority of all users of cannabis. Once again, we would add that a public policy must prevent use at an early age and at-risk behaviour.

The Commission was concerned that the use of cannabis would lead to the use of other drugs. Thirty years' experience in the Netherlands disproves this very clearly, as do the liberal policies of Spain, Italy and Portugal. And here in Canada, despite the growing increase in cannabis users, we have not had a proportionate increase in users of hard drugs.

The Commission was also concerned that legalization would mean increased use, among the young, in particular. We have not legalized cannabis, and we have one of the highest rates in the world. Countries adopting a more liberal policy have, for the most part, rates of usage lower than ours, which stabilized after a short period of growth.

Thirty years later, we note that:

- **Billions of dollars have been sunk into enforcement without any greater effect: there are more consumers, more regular users and more regular adolescent users;**
- **Billions of dollars have been poured into enforcement in an effort to reduce supply, without any greater effect: cannabis is more available than ever, it is cultivated on a large scale, even exported, swelling coffers and making organized crime more powerful; and**
- **There have been tens of thousands of arrests and convictions for the possession of cannabis and thousands of people have been incarcerated; however, use trends remain totally unaffected and the gap the Commission noted between the law and public compliance continues to widen.**

It is time to recognize what is patently obvious: our policies have been ineffective, because they are poor policies.

INEFFECTIVENESS OF THE CURRENT APPROACH

No clearly defined federal or national strategy exists. Some provinces have developed strategies while others have not. There has been a lot of talk but little significant action. In the absence of clear indicators accepted by all stakeholders to assess the effectiveness of Canadian public policy, it is difficult to determine whether action that has been taken is effective. Given that policy is geared to reducing demand (i.e. drug-use rates) and supply (by reducing the availability of drugs and pushing up drug prices), both these indicators may be used.

A look at trends in cannabis use, both among adults and young people, **forces us to admit that current policies are ineffective**. In chapter 6, we saw that trends in drug-use are on the increase. If our estimates do indeed reflect reality, no fewer that 2 million Canadians aged between 18 and 65 have used cannabis at least once over the past 12 months, while at least 750,000 young people between the ages of 14 and 17 use cannabis at least once per month; one third of them on a daily basis. This proportion appears, at least in the four most highly-populated provinces, to be increasing. Statistics suggest that both use and at-risk use is increasing.

Of course, we must clearly establish whether the ultimate objective is a drug-free society, at least one free of cannabis, or whether the goal is to reduce at-risk behaviour and abuse. This is an area of great confusion, since Canadian public policy continues to use vague terminology and has failed to establish whether it focuses on substance abuse as the English terminology used in several documents seems to suggest or on drug-addiction as indicated by the French terminology.

It is all very well to criticize the "trivialization" of cannabis in Canada to "explain" increases in use but it must also be established why, if this is indeed the case, this trivialization has occurred. It is also important to identify the root cause of this trivialization against a backdrop of mainly anti-drug statements. The courts and their lenient attitude might be blamed for this. Perhaps the judiciary is at the forefront of those responsible for cannabis policies and the enforcement of the law. It must also be determined whether sentences are really as lenient as some maintain. A major issue to be addressed is whether harsher sentences would indeed be an effective deterrent given that the possibility of being caught by the police is known to be a much greater deterrent. Every year, over 20,000 Canadians are arrested for cannabis possession. This figure might be as high as 50,000 depending on how the statistics are interpreted. This is too high a number for this type of conduct. However, it is laughable number when compared to the three million people who have used cannabis over the past 12 months. We should not think that the number of arrests might be significantly increased even if billions of extra dollars were allocated to police enforcement. Indeed, such a move should not even be considered.

A look at the availability and price of drugs, **forces us to admit that supply-reduction policies are ineffective**. Throughout Canada, above all in British Columbia and Québec, the cannabis industry is growing, flooding local markets, irritating the

United States and lining the pockets of criminal society. Drug prices have not fallen but quality has improved, especially in terms of THC content – even if we are sceptical of the reported scale of this improvement. Yet, police organizations already have greater powers and latitude – especially since the September 11, 2001 tragedy – in relation to drugs than in any other criminal matter. In addition, enforcement now accounts for over 90% of all illegal drug-related spending. To what extent do we want to go further down this road?

Clearly, current approaches are ineffective and inefficient – it is throwing taxpayers' money down the drain on a crusade that is not warranted by the danger posed by the substance. It has been maintained that drugs, including cannabis, are not dangerous because they are illegal but rather illegal because they are dangerous. This is perhaps true of other types of drugs, but not cannabis. We should state this clearly once and for all, for public good, stop our crusade.

PUBLIC POLICY BASED ON GUIDING PRINCIPLES

However much we might wish good health and happiness for everyone, we all know how fragile both are. Above all, we realize that health and happiness cannot be forced on a person, especially not by criminal law based on a specific concept of what is morally right. No matter how attractive calls for a drug-free society might be, and even if some people might want others to stop smoking, drinking alcohol, or smoking joints, we all realize that these activities are well and truly part of social reality and the history of humankind.

Consequently, what role should the State play? It should neither abdicate responsibility and allow drug markets to run rife, nor should it impose a particular way of life on people. Instead, we have opted for a concept whereby public policy **promotes and supports freedom for individuals and society as a whole**. For some, this would undoubtedly mean avoiding drug use. However, for others, the road to freedom might be via drug use. For society as a whole, this concept means a State that does not dictate what should be consumed and under what form. Support for freedom necessarily means flexibility and adaptability. It is for this reason that public policy on cannabis has to be clear while at the same time tolerant, to serve as a guide while at the same time avoiding imposing a single standard. This concept of the role of the State is based on the **principle of autonomy and individual and societal responsibility.** Indeed, it is much more difficult to allow people to make their own decisions because there is less of an illusion of control. It is just that: an illusion. We are all aware of that. It is perhaps sometimes comforting, but is likely to lead to abuse and unnecessary suffering. An ethic of responsibility teaches social expectations (not to use drugs in public or sell to children), responsible behaviour (recognizing at-risk behaviour and

being able to use moderately) and supports people facing hardship (providing a range of treatment).

From this concept of government action ensues a limited role for criminal law. As far as cannabis is concerned, **only behaviour causing demonstrable harm to others shall be prohibited**: illegal trafficking, selling to minors, impaired driving.

Public policy shall also draw on available knowledge and scientific research but without expecting science to provide the answers to political issues. Indeed, scientific knowledge does have a major role to play as a **support tool in decision-making,** at both an individual and government level. Indeed, science should play no greater role. It is for this reason that the Committee considers that a drug and dependency observatory and a research program should be set up: to help those decision makers that will come after us.

A CLEAR AND COHERENT FEDERAL STRATEGY

Although the Committee has focused on cannabis, we have nevertheless observed inherent shortcomings in the federal drug strategy. Quite obviously, there is no real strategy or focused action. Behind the supposed leadership provided by Health Canada emerges a lack of necessary tools for action, a patchwork of ad hoc approaches from one substance to another and piecemeal action by various departments. Of course, co-ordinating bodies do exist, but without real tools and clear objectives, each focuses its action according to its own particular priorities. This has resulted in a whole series of funded programs developed without any tangible cohesion.

Many stakeholders have expressed their frustration to the Committee at the jig-saw of seemingly evanescent pieces and at the whole gamut of incoherent decisions, which cause major friction on the front lines. Various foreign observers also expressed their surprise that a country as rich as Canada, which is not immune to psychoactive substance-related problems, did not have a "champion", a spokesperson or a figure of authority able to fully grasp the real issues while at the same time obtaining genuine collaboration of all stakeholders.

It is for this reason that we are recommending the creation of the position of National Advisor on Psychoactive Substances and Dependency to be attached to the Privy Council. We do not envisage this as a super body responsible for managing psychoactive substance-related budgets and action. In fact, we favour an approach similar to that of the *Mission interministérielle à la drogue et à la toxicomanie* in France over one modelled on the United States' Office of National Drug Control Policy. The Advisor would have a small dedicated staff, with the majority of staff loaned from the various federal departments and bodies concerned by the drugs issue.

The Advisor would be responsible: for advising the Cabinet and the Prime Minister on national and international psychoactive substance-related issues; for

ensuring co-ordination between federal departments and agencies; for overseeing the development of federal government psychoactive substance-related objectives and ensuring these objectives are satisfied; and to serve as a Canadian Government spokesperson on psychoactive substance-related issues at an international level.

Recommendation 1
The Committee recommends that the position of National Advisor on Psychoactive Substances and Dependency be created within the Privy Council Office; that the Advisor be supported by a small secretariat and that federal departments and agencies concerned by psychoactive substances second, upon request, the necessary staff.

NATIONAL STRATEGY SUSTAINED BY ADEQUATE RESSOURCES AND TOOLS

A federal policy and strategy do not in themselves make a national strategy. Provinces, territories, municipalities, community organizations and even the private sector all have a role to play in accordance with their jurisdiction and priorities. This is necessary and this diversity is worth encouraging. However, some harmonization and meaningful discussion on practices and pitfalls, on progress and setbacks, and on knowledge, are to be encouraged. Apart from the resource-starved piecemeal action of the Canadian Centre on Substance Abuse, there are all too few opportunities and schemes to promote exchanges of this type. **The current and future scale of drug and dependency-related issues warrants the Canadian Government earmarking the resources and developing the tools with which to develop fair, equitable and well-thought out policies**.

Like the majority of Canadian and foreign observers of the drug situation, we were struck by the relative lack of tools and measures for determining and following up on the objectives of public psychoactive substance policy. One might not agree with the numbers-focused goals set out by the Office of National Drug Control Policy for the reduction of drug use or for the number of drug treatment programs set up and evaluated. However, we have to admit that at least these figures serve as guidelines for all stakeholders and as benchmarks against which to measure success.

Similarly, one might not feel totally comfortable with the complex Australian goal-definition process, whereby the whole range of partners from the various levels of government, organizations and associations meet at a conference every five years. However, at least those goals agreed upon by the various stakeholders constitute a clear reference framework and enable better harmonization of action.

The European monitoring system with its focal points in each European Union country under the European Monitoring Centre for Drugs and Drug Addiction umbrella might seem cumbersome; and the American system of conducting various annual epidemiological studies might appear expensive. We might even acknowledge that there are problems with epidemiological studies, which are far from providing a perfect picture of the psychoactive substance-use phenomena. However, at least these tools, referred to and used throughout the Western world, enable the development of a solid information base, with which to analyse historical trends, identify new drug-use phenomena and react rapidly. In addition, it allows for an assessment of the relevance and effectiveness of action taken. No system of this type exists in Canada, which is the only industrialized Western country not to have such a knowledge structure.

It is for these reasons that the Committee recommends that the Government of Canada support various initiatives to develop a genuine national strategy. Firstly, the Government should call a national conference of the whole range of partners with a view to setting out goals and priorities for action over a five-year period. This conference should also identify indicators to be used in measuring progress at the end of the five-year period. Secondly, the Canadian Centre on Substance Abuse needs to be renewed. Not only does this body lack resources but it is also subject to the vagaries of political will of the Minister of Health. The Centre should have a budget in proportion with the scale of the psychoactive substance problem and should have the independence required to address this issue. Lastly, a Canadian Monitoring Agency on Drugs and Dependency should be created within the Centre.

Recommendation 2

The Committee recommends that the Government of Canada mandate the National Advisor on Psychoactive Substances and Dependency to call a high-level conference of key stakeholders from the provinces, territories, municipalities and associations in 2003, to set goals and priorities for action on psychoactive substances over a five-year period.

Recommendation 3

The Committee recommends that the Government of Canada amend the Canadian Centre on Substance Abuse enabling legislation to change the Centre's name to the *Canadian Centre on Psychoactive Substances and Dependency*; make the Centre reportable to Parliament; provide the Centre with an annual basic operating budget of 15 million dollars, to be increased annually; require the Centre to table an annual report on actions taken, the key issues, research and

trends in the federal Parliament and provincial and territorial assemblies and legislatures; mandate the Centre to ensure national co-ordination of research on psychoactive substances and dependency, and to conduct studies into specific issues; and mandate the Centre to undertake an assessment of the national strategy on psychoactive substance and dependency every five years.

Recommendation 4

The Committee recommends that in the legislation creating the Canadian Centre on Psychoactive Substances and Dependency, the Government of Canada specifically include provision for the setting up of a Monitoring Agency on Psychoactive Substances and Dependency within the Centre; provide that the Monitoring Agency be mandated to conduct studies every two years, in co-operation with relevant bodies, on drug-use trends and dependency problems in the adult population; work with the provinces and territories towards increased harmonization of studies of the student population and to ensure they are carried out every two years; conduct ad hoc studies on specific issues; and table a bi-annual report on drug-use trends and emerging problems.

A PUBLIC HEALTH POLICY

When cannabis was listed as a prohibited substance in 1923, no public debate or discussion was held on the known effects of the drug. In fact, opinions expressed were disproportionate to the dangers of the substance. Half a century later, the Le Dain Royal Commission of Inquiry on the Non-Medical Use of Drugs held a slightly more rational debate on cannabis and took stock of what was known about the drug. Commissioners were divided not so much over the nature and effects of the drug but rather over the role to be played by the State and criminal law in addressing public health-related goals. Thirty years after the Le Dain Commission report, we are able to categorically state that, **used in moderation, cannabis in itself poses very little danger to users and to society as a whole, but specific types of use represent risks for users.**

In addition to being ineffective and costly, criminalization leads to a series of harmful consequences: users are marginalized and exposed in a discriminatorily fashion to the risk of arrest and to the criminal justice system; society sees organized crime

enhance their power and wealth by benefiting from prohibition; and governments see their ability to conduct prevention of at-risk use diminished.

We would add that, **even if cannabis were to have serious harmful effects, one would have to question the relevance of using the criminal law to limit these effects**. We have demonstrated that criminal law is not an appropriate governance tool for matters relating to personal choice and that prohibition is known to result in harm which often outweighs the desired positive effects. However, current scientific knowledge on cannabis, its effects and consequences are such that this issue is not relevant to our discussion.

Indeed available data indicate that the scale of the cannabis use phenomenon can no longer be ignored. Chapter 6 indicated that no fewer than 30% of Canadians (12 to 64 years old) have experimented with cannabis at least once in their lifetime. In all probability, this is an underestimation. We have seen that approximately 50% of high school students have used cannabis within the past year. Nevertheless, a high percentage of them stop using and the vast majority of those who experiment do not go on to become regular users. Even among regular users, only a small proportion develop problems related to excessive use, which may include some level of psychological dependency. Consumption patterns among cannabis users do not inevitably follow an upward curve but rather a series of peaks and lulls. Regular users also tend to have a high consumption rate in their early twenties, which then either drops off or stabilizes, and in the vast majority of cases, ceases altogether in their thirties.

All of this does not in any way mean, however, that cannabis use should be encouraged or left totally unregulated. Clearly, it is a psychoactive substance with some effects on cognitive and motor functions. When smoked, cannabis can have harmful effects on the respiratory airways and is potentially cancerous. Some vulnerable people should be prevented, as much as possible, from using cannabis. This is the case for young people under 16 years of age and those people with particular conditions that might make them vulnerable (for example those with psychotic predispositions). As with alcohol, adult users should be encouraged to use cannabis in moderation. Given that, as for any substance, at-risk use does exist, preventive measures and detection tools should be established and treatment initiatives must be developed for those who use the drug excessively. Lastly, it goes without saying that education initiatives and severe criminal penalties must be used to deter people from operating vehicles under the influence of cannabis.

As for any other substance, there is at-risk use and excessive use. There is no universally accepted criterion for determining the line between regular use, at-risk use and excessive use. The context in which use occurs, the age at which users were introduced to cannabis, substance quality and quantity are all factors that play a role in the passage from one type of use to another. Chapters 6 and 7 identified various criteria, which we have collated in table form below.

Proposed Criteria for Differentiating Use Types

	Environment	Quantity	Frequency	Period of use and intensity
Experimental / Occasional	Curiosity	Variable	A few times over lifetime	None
Regular	Recreational, social Mainly in evening Mainly in a group	A few joints Less than one gram per month	A few times per month	Spread over several years but rarely intensive
At-risk	Recreational and occupational (to go to school, to go to work, for sport…) Alone, in the morning Under 16 years of age	Between 0.1 and 1 gram per day	A few times per week, evenings, especially weekends	Spread over several years with high intensity periods
Excessive	Occupational and personal problems No self regulation of use	Over one gram per day	More than once per day	Spread over several years with several months at a time of high intensity use

If **cannabis itself poses very little danger to the user and to society as a whole, some types of use involve risks**. It is time for our public policy to recognize this and to **focus on preventing at-risk use and on providing treatment for excessive cannabis users**.

Recommendation 5

The Committee recommends that the Government of Canada adopt an integrated *policy on the risks and harmful effects of psychoactive substances* covering the whole range of substances (medication, alcohol, tobacco and illegal drugs). With respect to cannabis, this policy shall focus on educating users, detecting and preventing at-risk use and treating excessive use.

A REGULATORY APPROACH TO CANNABIS

The **prohibition of cannabis does not bring about the desired reduction in cannabis consumption or problem use**. However, this approach does have a whole series of harmful consequences. Users are marginalized and over 20,000 Canadians are arrested each year for cannabis possession. Young people in schools no longer enjoy the same constitutional and civil protection of their rights as others. Organized crime benefits from prohibition and the criminalization of cannabis enhances their power and wealth. It is a well-known fact that society will never be able to stamp out drug use – particularly cannabis use.

Some might believe that an alternative policy signifies abandoning ship and giving up on promoting well-being for Canadians. Some might maintain that a regulatory approach would fly in the face of the fundamental values of our society. We believe, however, that the continued prohibition of cannabis jeopardizes the health and well-being of Canadians much more than the regulated marketing of the substance. In addition, we believe that the continued criminalization of cannabis undermines the fundamental values set out in the *Canadian Charter of Rights and Freedoms* and borne out by the history of a country based on diversity and tolerance.

We do not want to see cannabis use increase, especially among young people. Of note, the data from other countries that we compared in Chapters 6 and 20 indicate that countries such as the Netherlands, Australia or Switzerland, which have put in place a more liberal approach, have not seen their long-term levels of cannabis use rise. The same data also clearly indicate that countries with a very restrictive approach, such as Sweden and the United States, are poles apart in terms of cannabis use levels, and that countries with similar liberal approaches such as the Netherlands and Portugal are also at opposite ends of the spectrum, falling somewhere between Sweden and the United States. We have concluded that public policy itself has little effect on cannabis use trends and that other more complex and poorly-understood factors play a greater role in explaining the variations.

An exemption regime making cannabis available to those over the age of 16 would probably lead to an increase in cannabis use for a certain period. Use rates would then level out as interest wanes and as effective prevention programs are set up. This would then be followed by a roller-coaster pattern of highs and lows, as has been the case in most other countries.

This approach is neither one of total abdication nor a sign of giving up but rather a vision of the role of the State and criminal law as **developing and promoting but not controlling human action** and as **stipulating only necessary prohibitions** relating to the fundamental principle of respect for life, others and a harmonious community, and as **supporting and assisting others and not** judging and condemning difference.

We might wish for a drug-free world, fewer tobacco smokers or alcoholics or less prescription drug dependency, but we all know that we shall never be able to eliminate

these problems. More importantly, we should not opt to criminalize them. The Committee believes that the same healthy and respectful approach and attitude should be applied to cannabis.

It is for this reason that the Committee recommends that the Government of Canada amend the *Controlled Drugs and Substances Act* to create a criminal exemption scheme for the production and sale of cannabis under the authority of a licence. Licensing and the production and sale of cannabis would be subject to specific conditions, that the Committee has endeavoured to specify. For clarity's sake, these conditions have been compiled at the end of this section. It should be noted at the outset that the Committee suggests that cigarette manufacturers be prohibited from producing and selling cannabis.

Recommendation 6

The Committee recommends that the Government of Canada amend the *Controlled Drugs and Substances Act* to create a criminal exemption scheme. This legislation should stipulate the conditions for obtaining licences as well as for producing and selling cannabis; criminal penalties for illegal trafficking and export; and the preservation of criminal penalties for all activities falling outside the scope of the exemption scheme.

Recommendation 7

The Committee recommends that the Government of Canada declare an amnesty for any person convicted of possession of cannabis under current or past legislation.

A COMPASSION-BASED APPROACH FOR THERAPEUTIC USE

In Chapter 9, we noted that cannabis has not been approved as a medicinal drug in the pharmacological sense of the word. In addition to the inherent difficulties in conducting studies on the therapeutic applications of cannabis, there are issues arising from the current legal environment and the undoubtedly high cost to governments of conducting such clinical studies.

Nevertheless, we do not doubt that, for some medical conditions and for certain people, cannabis is indeed effective and useful therapy. Is it more effective than other types of medication? Perhaps not. Can physicians currently prescribe cannabis at a known dosage? Undoubtedly not. Should persons suffering from certain physical

conditions diagnosed by qualified practitioners be permitted to use cannabis if they wish to do so? Of this, we are convinced.

Regulations made in 2001 by the Health Canada, even though they are a step in the right direction, are fundamentally unsatisfactory. They do not facilitate access to therapeutic cannabis. They do not consider the experience and expertise available in compassion clubs. These regulations only govern marijuana and do not include cannabis derivatives such as hashish and cannabis oils.

It is for these reasons that the Committee recommends that Health Canada amend the *Marihuana Medical Access Regulations* in order to allow compassionate access to cannabis and its derivatives. As in the previous chapter, proposed rules have been compiled at the end of this chapter.

Recommendation 8

The Committee recommends that the *Marihuana Medical Access Regulations* be amended to provide new rules regarding eligibility, production and distribution of cannabis for therapeutic purposes. In addition, research on cannabis for therapeutic purposes is essential.

PROVISIONS FOR OPERATING A VEHICLE UNDER THE INFLUENCE OF CANNABIS

In chapter 8, we discussed the fact that research has not clearly established the effects of cannabis when taken alone on a person's ability to operate a vehicle. Nevertheless, there is enough evidence to suggest that operating a vehicle while under the influence of cannabis alters motor functions and effects a person's ability to remain in his or her lane. We have also established that the combined effects of cannabis and alcohol impair faculties even more than alcohol taken alone. Epidemiological studies have shown that a certain number of cannabis users do drive under the influence of the substance and that a large proportion of these people, mainly the young, appear to believe that cannabis does not impair their ability to drive.

This chapter also indicated that no reliable and non-intrusive road-side detection tools exist. Saliva-based equipment is a promising development but for the time being, provide random results. We have also established that a visual recognition system, which has mainly been developed and assessed in the United States, is a reliable way of detecting drug-induced impaired driving faculties.

Recommendation 9
The Committee recommends that the Criminal Code be amended to lower permitted alcohol levels to 40 milligrams of alcohol per 100 millilitres of blood, in the presence of other drugs, especially, but not exclusively cannabis; and to admit evidence from expert police officers trained in detecting persons operating vehicles under the influence of drugs.

RESEARCH

Research on psychoactive substances, and particularly on cannabis, has undergone a boom over the past 20 years. The Committee was able to fully grasp the actual extent of this increase, since we faced the challenge of summarizing it. Not all research is of the same quality and the current political and legal climate governing cannabis hampers thorough and objective studies. Nevertheless, a solid fact base was available to the Committee, on which to base its foregoing conclusions and recommendations.

However, more research needs to be done in a certain number of specific areas. In Chapter 6, we established that a lack of practical research on cannabis users has resulted in only a limited amount of information on contexts of use being available. It is also currently difficult to establish criteria on the various types of cannabis use in order to guide those responsible for prevention. The Committee suggests that cannabis use of over one gram per day constitutes excessive use and that between 0.1 and one gram per day equates to at-risk use. We also suggest that any use below 16 years of age is at-risk use. This is of course enlightened speculation, but speculation nevertheless, which remains to be explored.

In Chapters 16 and 17, we referred to the fact that we know very little about the most effective prevention practices and treatment. Here also, the current context hindered. As far as prevention is concerned, the more or less implicit "*just say no*" message and the focus on cannabis use prevention are strategies that have been dictated by the prohibition-based environment. In terms of treatment for problem users, abstinence-based models have long been the dominant approach and continue to sit very poorly with harm-reduction-based models. Thorough assessment studies are required.

The Canadian Centre on Psychoactive Substances and Dependency must play a key role in co-ordinating and publishing the results of studies. The Centre does not have to conduct research itself. This can and indeed must sometimes be carried out by academics. The Health Research Institutes are also natural players. However, it is important to clearly identify a single central body to collect research information. This will enable the information to be distributed as widely possible and, we hope, used.

Recommendation 10
The Committee recommends that the Government of Canada create a national fund for research on psychoactive substances and dependency to fund research on key issues - more particularly on various types of use, on the therapeutic applications of cannabis, on tools for detecting persons operating vehicles under the influence of drugs and on effective prevention and treatment programs; that the Government of Canada mandate the Canadian Centre on Psychoactive Substances and Dependency to co-ordinate national research and serve as a resource centre.

CANADA'S INTERNATIONAL POSITION

The Committee is well aware that were Canada to choose the rational approach to regulating cannabis that we have recommended, it would be in contravention of the provisions of the various international conventions and treaties governing drugs. We are also fully aware of the diplomatic implications of this approach, in particular in relation to the United States.

We are keen to avoid replicating, at the Canada-US border, the problems that marked relations between the Netherlands, France, Belgium and Germany over the issue of drugs-tourism between 1985 and 1995. This is one of the reasons that justifies restricting the distribution of cannabis for recreational purposes to Canadian residents.

We are aware of the fact that a significant proportion of the cannabis produced in Canada is exported, mainly to the United States. We are also aware that a considerable proportion of heroin and cocaine comes into Canada via the United States. We are particularly cognisant of the fact that Canadian cannabis does not explain the increase in cannabis use in the United States. It is up to each country to get its own house in order before criticizing its neighbour.

Internationally, Canada will either have to temporarily withdraw from the conventions and treaties or accept that it will be in temporary contravention until the international community accedes to its request to amend them. The Committee opts for the second approach, which seems to us to be more consistent with the tradition and spirit of Canadian foreign policy. In addition, we have seen that international treaties foster the imbalanced relationship between the Northern and Southern hemispheres by prohibiting access to plants, including cannabis, produced in the Southern hemisphere, while at the same time developing a regulatory system for medication manufactured by the pharmaceutical industry in the Northern hemisphere.

Canada could use this imbalanced situation to urge the international community to review existing treaties and conventions on psychoactive substances.

Canada can and indeed should provide leadership on drug policy. Developing a national information and action infrastructure would undoubtedly be key to this. **Canada must also play a leading role in the Americas**. We believe that Canada enjoys a favourable international reputation and that it can promote the development of fairer and more rational drug– in particular cannabis - policies. We also contend that Canada should strive for the creation of a European Observatory-style Drug and Dependency Observatory for the Americas within the Organization of American States.

Recommendation 11

The Committee recommends that the Government of Canada instruct the Minister of Foreign Affairs and International Trade to inform the appropriate United Nations authorities that Canada is requesting that conventions and treaties governing illegal drugs be amended; and that the development of a Drugs and Dependency Observatory for the Americas be supported by the Government of Canada.

PROPOSALS FOR IMPLEMENTING THE REGULATION OF CANNABIS

FOR THERAPEUTIC AND RECREATIONAL PURPOSES

Amendments to the *Marihuana Medical Access Regulations* (Production and sale of cannabis for therapeutic purposes)

A. Eligible person

A person affected by one of the following: wasting syndrome; chemotherapy treatment; fibromyalgia; epilepsy; multiple sclerosis; accident-induced chronic pain; and some physical condition including migraines and chronic headaches, whose physical state has been certified by a physician or an individual duly authorized by the competent medical association of the province or territory in question, may choose to buy cannabis and its derivatives for therapeutic purposes. The person shall be registered with an accredited distribution centre or with Health Canada.

B. Licence to distribute

A Canadian resident may obtain a licence to distribute cannabis and its derivatives for therapeutic purposes. The resident must undertake to only sell cannabis and its derivatives to eligible persons; to only sell cannabis and its derivatives purchased from producers duly licensed for this purpose; to keep detailed records on the medical conditions and their development, consumption and the noted effects on patients; to take all measures needed to ensure the safety of the cannabis products and to submit to departmental inspections.

C. Licence to produce

A Canada resident may obtain a licence to produce cannabis and its derivatives for therapeutic purposes. The resident must undertake: not to hold a licence to produce cannabis for non therapeutic purposes; to take the measures necessary to ensure the consistency, regularity and quality of crops; to take the measures necessary to ensure the security of production sites; to know and document the properties and concentrations of each harvest with respect to Delta 9 THC; to sell only to accredited distribution centres and to submit to departmental inspections.

D. Other proposals

- Ensure that expenses relating to the use of cannabis for therapeutic purposes will be eligible for a medical expenses tax credit;

- Establish a program of research into the therapeutic applications of cannabis, by providing sufficient funding; by mandating the ***Canadian Centre on Psychoactive Substances and Dependency*** to co-ordinate the research program; and by providing for the systematic study of clinical cases based on the documentation available in organizations currently distributing cannabis for therapeutic purposes and in future distribution centres; and
- Ensure that the advisory committee on the therapeutic use of cannabis represents all players, including distribution centres and users.

Amendment to the
***Controlled Drugs and Substances Act* (CDSA)**
(Production and sale of cannabis for non therapeutic purposes)

A. General aims of the bill

- To reduce the injurious effects of the criminalization of the use and possession of cannabis and its derivatives;
- To permit persons over the age of 16 to procure cannabis and its derivatives at duly licensed distribution centres; and
- To recognize that cannabis and its derivatives are psychoactive substances that may present risks to physical and mental health and, to this end, to regulate the use and trade of these substances in order to prevent at-risk use and excessive use.

B. Licence to distribute

Amend the Act to create a criminal exemption scheme to the criminal offences provided in the CDSA with respect to the distribution of cannabis. A Canadian resident could obtain a licence to distribute cannabis. The resident must undertake **not to distribute to persons under the age of 16; must never have been sentenced for a criminal offence, with the exception of offences related to the possession of cannabis, for which an amnesty will be declared**; and must agree to procure cannabis only from duly licensed producers. In addition, in accordance with the potential limits imposed by the *Canadian Charter of Rights and Freedoms*, licensed distributors shall not display products explicitly and shall not advertise in any manner.

C. Licence to produce

Amend the Act to create a criminal exemption scheme to the criminal offences provided in the CDSA with respect to the production of cannabis. A Canadian resident could obtain a licence to produce cannabis. The resident must undertake to only sell to duly licensed distributors; to sell only marihuana and hashish with a

THC content of 13% or less; to limit production to the quantity specified in the licence; to take the measures needed to ensure the security of production sites; to keep detailed records of quantities produced, crops, levels of THC concentration and production conditions; and to submit to departmental inspections. No person charged with and sentenced for criminal offences, with the exception of the possession of cannabis, for which an amnesty will be declared, shall be granted a licence. No person or legal entity, directly or indirectly associated with the production, manufacture, promotion, marketing or other activity connected with tobacco products and derivatives shall be granted a licence. In accordance with the potential limits imposed by the *Canadian Charter of Rights and Freedoms*, cannabis products and their derivatives shall not be advertised in any manner.

D. Production for personal use

Amend the Act to create a criminal exemption scheme to the criminal offences provided in the CDSA in order to permit the personal production of cannabis so long as it is not sold for consideration or exchange in kind or other and not advertised or promoted in any other way. In addition, quantities shall be limited to ensure production is truly for personal consumption.

E. Consumption in public

Consumption in public places shall be prohibited.

F. International trade

All forms of international trade, except those explicitly permitted under the Act shall be subject to the penalties provided in the CDSA for illegal trafficking.

G. Other proposals

- Ensure the establishment of a National Cannabis Board with duly mandated representatives of the federal government and the governments of the provinces and territories. The Board would keep a national register on the production and sale of cannabis and its derivatives, set the amount and distribution of taxes taken on the sale of cannabis products and ensure the taxes collected on the production and sale of cannabis and derivatives are directed solely to prevention of at-risk use, treatment of excessive users, research and observation of trends and the fight against illegal trafficking.
- The provinces and territories would continue to develop prevention measures that should be directed at at-risk use, as a priority. The ***Canadian Centre on Psychoactive Substances and Dependency*** should be mandated

to collect best prevention practices and ensure an exchange of information on effective practices and their evaluation.

- The provinces and territories would continue to develop support and treatment measures that should be directed at excessive use, as a priority. The ***Canadian Centre on Psychoactive Substances and Dependency*** should be mandated to collect best prevention practices and ensure an exchange of information on effective practices and their evaluation.
- Increase resources available to police and customs to fight smuggling, export in all its forms and cross-border trafficking.

BIBLIOGRAPHY

I – BIBLIOGRAPHICAL REFERENCES

Abt Associates. 2001. *The Price of Illicit Drugs : 1981 through the Second Quarter of 2000.* Washington (D.C.) : Office of National Drug Control Policy

Adhikari, P. and A. Summerill. 2000. *1998 National Drug Strategy Household Survey: Detailed Findings.* Canberra : Australian Institute of Health and Welfare. (Drug Statistics Series No. 6). (Available online at: http://www.aihw.gov.au/publications/health/ndshs98d/index.html)

Adlaf, E.M. and A. Ialomiteanu. 2000. *CAMH Monitor Report : Addiction and Mental Health Indicators among Ontario Adults, 1977-2000.* Toronto : Centre for Addiction and Mental Health.

Adlaf, E.M. and A. Paglia. 2001. *Drug Use among Ontario Students 1977-2001. Findings from the OSDUS.* Toronto : Centre for Addiction and Mental Health.

Aebi, M.F., Killias, M. and D. Ribeau. 1999. « Prescription médicale de stupéfiants et délinquance : Résultats des essais suisses ». *Criminologie* 32(2) : 127-148.

Alexander, B.K. 2000. « The globalization of addiction. » *Addiction Research.* 8(6) : 504.

Ali, R. et. al. 1998. *The Social Impacts of the Cannabis Expiation Notice Scheme in South Australia.* Canberra : Department of Health and Aged Care. (Available online at: http://www.health.gov.au/pubhlth/publicat/drugs.htm)

Allain, J. 1997. *Bill C-8 : The Controlled Drugs and Substances Act.* Ottawa : Library of Parliament – Parliamentary Research Branch.

Allan, Travis. 2001. « Drug Laws: the debate nobody wants ». *The Guardian.* May 14.

Anslinger H.J. and W. Oursler. «The War against the Murderers ». in Walker III, W.O. (ed.). 1996. *Drugs in the Western Hemisphere: An Odyssey of Cultures in Conflict.* Wilmington (Delaware) : Scholarly Resources Inc.

Anthony J.C. and J.E. Helzer. 1991. «Syndromes of Drug Abuse and Dependence ». in Robins, L.N. and D.A. Regier (eds.). 1991. *Psychiatric Disorders in America.* New York. Free Press : 116-154

Anthony, J.C. et. al. 1994. « Comparative Epidemiology of Dependence on Tobacco, Alcohol, Controlled Substances and Inhalants : Basic Findings from the National Comorbidity Survey ». *Experimental and Clinical Psychopharmacology.* 2 : 244-268.

Aquatias. S. et. al. 1997. *L'usage dur des drogues douces, recherche sur la consommation de cannabis dans la banlieue parisienne.* Paris : OFDT.

Aquatias, S. 1999. « Usages du cannabis et situations sociales: Réflexion sur les conditions sociales des différentes consommations possibles de cannabis. » in Faugeron, C. (ed.). 1999. *Les drogues en France.* Paris : Georg.

Ashton, C.H. 2001. « Pharmacology and Effects of Cannabis: A brief review. » *British Journal of Psychiatry.* 178 : 101-106.

Ati-Dion, G. 1999. *The Structure of Drug Prohibition in International Law and in Canadian Law.* Montreal : University of Montreal - School of Criminology.

Bala, N. and al. (dir.). 2002. *Juvenile Justice Systems: An International Comparison of Problems and Solutions.* Toronto : Thompson Educational Publishing.

Barré, M.D., Pottier, M.L. et S. Delaître. 2001. *Toxicomanie, police, justice : trajectoires pénales.* Paris : OFDT.

Beardsley, R.M et. al. 1986. «Dependence on THC in rhesus monkeys ». *Journal of Pharmacology and Experimental Therapeutics . Exp. Ther.* 239(2) : 311-319.

Beauchesne, Line. 1991. *La légalisation des drogues… Pour mieux en prévenir les abus.* Montreal : Méridien.

Beauchesne, Line. 1999. « À propos du cannabis, que faire? ». *L'écho-toxico.* Fall 1999. 9(2).

Belenko, Steven R. (dir.). 2000. *Drugs and Drug Policy in America: A Documentary History.* Westport (Connecticut) : Greenwood Press.

Beltrame, Julian. 2001. « Reefer Madness : The Sequel. » *MacLean's.* 114(32) : 22-25.

Bergeron, H. 1996. *Soigner la toxicomanie. Les dispositifs de soins entre idéologie et action.* Paris : L'Harmattan.

Bergeron, H. 1998. « Comment soigner les toxicomanes? », *Sociétal,* June-July 1998 : 45-49.

Bernat de Celis, J. 1996. *Drogues : Consommation interdite.* Paris : L'Harmattan.

Bewley-Taylor, D.R. 1999. *The United States and International Drug Control.* London et New York : Printer.

Bigelow, G.E. 1985. *Identifying Types of Drug Intoxication: Laboratory Evaluation of a Subject-Examination Procedure.* Quoted in Sandler, D. 2000. «Expert and Opinion Testimony of Law Enforcement Officers Regarding Identification of Drug Impaired Drivers. ». *University of Hawaii Law Review* 23(1) : 150-181.

Bisiou, Y., (1999) « Histoire des politiques criminelles : Le cas des régies françaises des stupéfiants. » in Faugeron, C., (ed.). 1999. *Les drogues en France. Politiques, marchés, usages.* Paris : Georg.

Boekhout van Solinge, T. 1997 *The Swedish Drug Control System : An in-depth Review and Analysis.* Amsterdam : Centre for Drug Research – University of Amsterdam.

Boekhout van Solinge, T. 1998. «La Politique de drogue aux Pays-Bas: un essai de changement ». *Déviance et Société.* 22 : 69 à 71.

Boggio, Y. et. al. 1997. *Apprendre à gérer : La politique suisse en matière de drogue.* Genève : Georg.

Boyd, N. 1991. *High society : Illegal and Legal Drugs in Canada.* Toronto : Key Porter Books.

Brereton, D. 2000. «The History and Politics of Prohibition». in Stokes, G., Chalk, P. and K. Gillen. 2000. *Drugs and Democracy: In search of new directions.* Carlton South: Melbourne University Press.

British Columbia Compassion Club Society. 2001. *BCCCS Response to Health Canada's Proposed Medical Marijuana Access Regulations.* Vancouver. May 4, 2001.

Brucker, Theresa. 2002. *The Practical Guide to the Controlled Drugs and Substances Act.* Scarborough : Carswell (Fourth Edition).

Bruun, Kettil, Pan, L. and I. Rexed. 1975. *The Gentlemen's Club: International Control of Drugs and Alcohol.* Chicago : University of Chicago Press.

Caballero, F. and Y. Bisiou (2000) *Droit de la drogue.* Paris : Dalloz (Second Edition).

Campbell, I. 1976. " The Amotivational Syndrome and Cannabis Use with Emphasis on the Canadian Scene ". *Annals of the New York Academy of Sciences.* 282 : 33-36.

Campodònico, H. 1996. « Drug Trafficking, Money and Neo-liberal Economics : Perverse Effects for a Developing Country. » in Dorn, N. et. alii. (eds.). 1996. *European Drug Policies and Enforcement.* London : Macmillan Press.

Canada. 1970. *Interim Report of the Commission of Inquiry into Non-Medical Use of Drugs.* (Le Dain Commission) Ottawa : Information Canada.

Canada. 1972. *Cannabis : A Report of the Commission of Inquiry into Non-Medical Use of Drugs.* (Le Dain Commission) Ottawa : Information Canada.

Canada. 1973. *Final Report of the Commission of Inquiry into Non-Medical Use of Drugs.* (Le Dain Commission) Ottawa : Information Canada.

Canada. 1987. *Federal Government Launches Co-ordinated Action on Drug Abuse.* News Release.

Canada. 1987. *National Drug Strategy: Prevention, Treatment, Research, Control Components.* Ottawa : Department of Health and Welfare.

Canada. 1987. *National Drug Strategy: International Components.* Ottawa : Department of Health and Welfare.

Canada. 1987. *National Drug Strategy: Enforcement Components.* Ottawa : Department of Health and Welfare.

Canada. 1987. *National Drug Strategy: Proceeds of Crime Components.* Ottawa : Department of Health and Welfare.

Canada. 1988. *Action on Drug Abuse: Making a Difference.* Ottawa : Department of Supply and Services.

Canada. 1991. *Canada's Drug Strategy.*Canada. 1992. *Canada's Drug Strategy – Phase II.*

Canada. 1994. *Canada's Drug Strategy – Phase II: A situation paper.* Ottawa: Health Canada

Canadian Center on Substance Abuse. 1999. *Canadian Profile: Alcohol, Tobacco and other Drugs.* Ottawa : CCSA.

Canadian Medical Protective Association. 2001. *What To Do When Your Patients Apply For A Licence To Possess Marijuana For Medical Purposes.* October 2001.

Canadian Medical Protective Association. 2001. *Letter to the Honourable Allan Rock, Q.C.*, November 2001.

Canadian Police Association (CPA). 2001. *Brief submitted to the Senate of Canada Special Committee on Illegal Drugs.* Ottawa : CPA.

Caplan, G.A. and B.A. Brigham. 1990. «Marijuana smoking and carcinoma of the tongue: Is there an association? ». *Cancer.* 66 : 1005-1006.

Carrier, N. 2000. *Discours de patrouilleurs montréalais sur la détection de l'infraction de possession de drogues prohibées.* Montreal : School of Criminology – University of Montreal

Centre canadien de lutte contre l'alcoolisme et les toxicomanies. 1996. *La politique antidrogue au Canada. Mémoire au Comité permanent de la Santé de la Chambre des communes.* Ottawa : CCLAT.

Centre d'aide et d'accueil en toxicomanie (CAAT), *La mise en application de la loi.* (Available online at: http://caat.multimania.com/info/app_loi.htm.)

Cesoni, L.L. .1999. *Usage et actes préparatoires de l'usage des drogues illicites : les choix en matière d'incrimination – Analyse comparative de l'usage de drogues illicites de sept législations européennes.* in Conseil fédéral suisse. 2001. *Message concernant la révision de la loi sur les stupéfiants.*

Changeux, J.P. and P. Ricoeur. 1998. *Ce qui nous fait penser. La nature et la règle.* Paris : Odile Jacob.

Channabasavanna, M, et. al. 1999. « Mental and behavioural disorders due to cannabis use ». in Kalant H. et. al. (eds.). 1999. *The Health Effects of Cannabis* , Toronto : CAMH.

Charras, I. 1998. « L'État et les stupéfiants : archéologie d'une politique publique répressive. » in *Drogue. Du bon usage des politiques publiques.* Les cahiers de la sécurité intérieure. (32).

Chatterjee, S.K. 1988. *A Guide to the International Drugs Conventions.* London : Commonwealth Secretariat

Chevalier, S. and O. Lemoine. 2000. « Consommation de drogues et autres substances psychoactives » in *Enquête sociale et de santé 1998.* Québec : Institut de la statistique du Québec

Cienski, Jan and C. Hanlon. 2002. "U.S. fears drug spillover from Canada: Border seizures up dramatically in wake of Sept. 11." *National Post*. 17 mai : A 12.

Clark, P.A.. 2000. « The Ethics of Medical Marijuana : government restrictions vs. medical necessity. ». *Journal of Public Health Policy.* 21 : 40-60.

Cohen, P.D.A. and H.L. Kaal. 2001. *The Irrelevance of Drug Policy: Patterns and careers of experienced cannabis use in the population of Amsterdam, San Francisco and Bremen.* Amsterdam : University of Amsterdam (CEDRO).

Collin, C. 2001. *National Drug Policy: France.* Ottawa : Library of Parliament – Parliamentary Research Branch. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Collin, C. 2002. *National Drug Policy: Switzerland.* Ottawa : Library of Parliament – Parliamentary Research Branch. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Comité consultatif national d'éthique. 1994. *Rapports sur les toxicomanies.* Report n° 43. 23 November 1994 : 19. (Available online at: http://www.ccne-ethique.org/français/start.htm)

Comité permanent de lutte à la toxicomanie. 1999. *Avis sur la déjudiciarisation de la possession simple de cannabis.* Montreal : CPLT.

Comité permanent de lutte à la toxicomanie. 2000. *Consultation 2000. La toxicomanie au Québec : Cap sur une stratégie nationale.* Quebec City : CPLT.

Comité permanent de lutte à la toxicomanie. 2001. *Drogues. Savoir plus. Risquer Moins.* Montreal : Stanké. (Quebec's Edition)

Commission fédérale pour les questions liées aux drogues. 1999. *Rapport sur le cannabis.* Berne : Office fédéral de la santé publique.

Compton, P.R. 1986. *Field Evaluation of the Los Angeles Police Department Drugs Detection Procedure.* Quoted in Sandler, D. 2000. « Expert and Opinion Testimony of Law Enforcement Officers Regarding Identification of Drug Impaired Drivers. ». *University of Hawaii Law Review* 23(1) : 150-181.

Conseil fédéral suisse. 2001. *Message concernant la révision de la loi sur les stupéfiants.*

Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988 (CTS 1990/42).

Convention on Psychotropic Substances, 1971 (CTS 1988/35).

Correctional Service Canada. 2001. « Profiling the drug offender population in Canadian federal corrections ». *Forum on Corrections Research.* 13 (3) : 25-29.

Currie, D.P. 2000. *The Constitution of the United States: A Primer for the People.* Chicago : University of Chicago Press.

Curtis, C.K. 1999. *The Efficacy of the Drug Abuse Resistance Education Program (DARE) in West Vancouver Schools. Part 1 – Attitudes toward DARE : An examination of opinions, preferences, and perceptions of students, teachers, and parents.* GRC West Vancouver.

De Koninck, Thomas. 2002. *The Role of Knowledge and Culture in Public Policy on Illegal Drugs.* Quebec City: Laval University – Professor of Philosophy. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

De Kort, M. 1994. « A Short History of Drugs in the Netherlands. » in Leuw, E. and I. Haen Marshall (eds.). 1994. *Between Prohibition and Legalization. The Dutch experiment in drug policy*. Amsterdam : Kugler.

Declaration of the International Conference on Drug Abuse and Illicit Trafficking and Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control, Document of United Nations, ST/NAR/14, 1988.

Department of Health and Social Affairs. 2002. *National Action Plan on Narcotic Drugs*, Briefing Note.

Department of Justice – United States of America. 1990. *Correctional Population in the United States Prisoners in 1989.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice of United States of America. 1991. *Correctional Population in the United States Prisoners in 1990.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1992. *Correctional Population in the United States Prisoners in 1991.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1992. *Jail Inmates 1990.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1993. *Correctional Population in the United States Prisoners in 1992.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1994. *Correctional Population in the United States Prisoners in 1993.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1995. *Jail and Jail Inmates 1993-1994.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States – America. 1995. *Correctional Population in the United States Prisoners in 1994.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1996. *Correctional Population in the United States Prisoners in 1995.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1998. *Prisoners in 1997.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1999. *Prisoners in 1998.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 2000. *Prisoners in 1999.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 2000. *Correctional Population in the United States Prisoners in 1997.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Devane, W.A. et. al. 1992. « Isolation and structure of a brain constituent that binds to the cannabinoid receptor ». *Science*. 258 (5090) : 1946-1949.

Direction de la Santé publique. 1997. *Les inégalités sociales de la santé. Rapport annuel 1998 sur la santé de la population.* Montreal : Régie régionale de la santé et des services sociaux de Montréal-Centre.

Dolin, B. 2001. *National Drug Policy: Netherlands.* Ottawa : Library of Parliament – Parliamentary Research Branch. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Dolin, B. 2002. *National Drug Policy: United States of America.* Ottawa : Library of Parliament – Parliamentary Research Branch. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Donald, P.J. 1991. « Marijuana and upper aerodigestive tract malignancy in young patients ». in Nahas, G. and C. Latour (eds.). 1991. *Physiopathology of Illicit Drugs: Cannabis, Cocaine, Opiates.* Oxford : 39-54.

Donald, P.J. 1991. « Advanced malignancy in the young marijuana smoker ». in Friedman, H. et. al., (eds.). 1991. *Drugs of Abuse, Immunity and Immunodeficiency.* London. 33-36.

Dorn, N. and A. Jamieson. 2001. *European Drug Laws : The Room for Manoeuvre.* London : DrugScope.

Doyle, C. 2000. *Drug Offences: Maximum Fines and Terms of Imprisonment for Violation of the Federal Controlled Substances Act and Related Laws.* Washington (D.C.) : Library of Congress – Congressional Research Service.

DrugScope. 2001. *United Kingdom. Drug Situation 2000.* Report to the EMCDDA. London : Drugscope.

Dubois, François. 2002. *The Federal Parliament and the Evolution of Canadian Legislation on Illegal Drugs.* Ottawa : Senate Special Committee on Illegal Drugs. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Duke, Stephen B. 1995. « Commentary: Drug Prohibition: An Unnatural Disaster ». 27 *Conn. L. Rev.* 571.

DuPont, R.L. 1999. «Examining the Debate on the Use of Medical Marijuana. » *Proceedings of the Association of American Physicians.* 111(2) : 169.

Dupras, Daniel. 1998. *Canada's International Obligations Under the Leading International Conventions on the Control of Narcotics.* Ottawa : Library of Parliament – Parliamentary Research Branch. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Editorial. 1997. «Decriminalizing Drugs». *Ottawa Citizen.* April 12, 14, 15 and 16.

Ehrenberg, A. 1995 *L'individu incertain.* Paris : Calman Lévy.

Ehrlich, S. 2000. « The Increasing Federalization of Crime». 32 *Ariz. St.L.J.* 825.

ElSohly, M.A., et. al. 2000 «Potency trends of delta9-THC and other cannabinoids in confiscated marijuana from 1980-1997. ». *Journal of Forensic Sciences.* 45(1) : 24-30.

EMCDDA. 2001. *Decriminalization in Europe? Recent Developments in Legal Approaches to Drug Use.* Lisbonne : EMCCDDA.

Erickson, P. and B. Fisher. 1995. *Canadian Cannabis Policy: The Impact of Criminalization, the Current Reality and Future Police Options.* Bremen (Germany) : Paper presented at the *International Symposium on Cannabis Policy, Criminal Law and Human Rights* (October 5-7 (1995)).

European Monitoring Center for Drugs and Drug Addiction (EMCDDA) *France Country Profile: French Drug Legislation.* European Legal Database on Drugs. (Available online at: http://eldd.emcdda.org/databases/eldd_national_reviews.cfm?country=FR.)

European Monitoring Center for Drugs and Drug Addiction. *Country Profiles – Sweden*, European Legal Database on Drugs.

European NGO Council on Drugs and Development. 2001. *A Snapshot of European Drug Policies : Report on the state of drug policies in 12 European countries.*

Executive Office of the President of United States. 2001. *Summary: FY 2002 National Drug Control Budget.* Washington (D.C.) : The White House.

Fant, R.V. et. al. 1998. « Acute and residual effects of marijuana in humans. » *Pharmacology, Biochemistry and Behavior.* 60 : 777-784.

Fergusson, D.M. and L.J. Horwood. 2000. «Cannabis use and dependence in a New Zealand birth cohort. ». *New Zealand Medical Journal.* 113 : 156-158.

Fischer, B. et. al. 1998. « Cannabis use in Canada : policy options for control ». *Policy Options.* 19 : 34-38.

Fligiel, S.E.G. et. al. 1988. « Pulmonary pathology in marijuana smokers ». in Chesher G. et. al. (eds.). 1988. *Marijuana: An International Research Report.* (National Campaign Against Drug Abuse – Monograph 7 : 43-48). Canberra : Australian Government Publishing Service.

Fligiel, S.E.G. et. al. 1997. « Tracheo-bronchial histopathology in habitual smokers of cocaine, marijuana or tobacco ». *Chest.* 112: 319-326.

Focus on the Family. 2002. *Brief submitted to the Senate Special Committee on Illegal Drugs.* Richmond (British Columbia).

Fontana, James A. 1997. *The Law of Search and Seizure in Canada.* Toronto : Butterworths (Fourth Edition).

Fried, P.A. 1995. « Prenatal exposure to marijuana and tobacco during infancy, early and middle childhood : Effects and attempts at a synthesis. ». *Archives of Toxicology.* 17.

Fried, P.A. and B. Watkinson. 1999. « 36- and 48-month neurobehavioral follow-up of children prenatally exposed to marijuana, cigarettes and alcohol ». *Journal of Deviant Behavior and Pediatrics.* 11 : 49-58.

Friman, H. Richard. 1996. *NarcoDiplomacy: Exporting the U.S. War on Drugs*, Ithaca (N.Y.) : Cornell University Press.

Gaoni, Y and R. Mechoulam. 1964. « Isolation, structure and partial synthesis of an active constituent of hashish. ». *Journal of the American Chemistry Society*. 86 : 1646-1647.

Gardner, D. 2000. « Why the war on drug has failed : Uncle Sam's war ». *Ottawa Citizen*. September 5.

Giffen, P.J., Endicott, S. and S. Lambert. 1991. *Panic and Indifference: The Politics of Canada's Drug Laws*, Ottawa: Canadian Centre on Substance Abuse.

Gilmore, W. 1990. *Combating International Drugs Trafficking: The 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, London : Commonwealth Secretariat

Goetz, David. 2001. *Drug Prohibition and the Constitution*. Ottawa : Library of Parliament – Parliamentary Research Branch. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Goodrich, Leland M. 1960. « New Trends in Narcotics Control ». *International Conciliation*. 530.

Grapendaal, M., Leuw, E., and H. Nelen. 1995. *A World of Opportunities: Life-Style and Economic Behaviour of Heroin Addicts in Amsterdam*. New York : S.U.N.Y. Press. Quoted in Boekhout van Solinge, T. 1999. «Dutch Drug Policy in a European Context ». *Journal of Drug Issues*. 29(3) : 511. (Available online at: www.cedro-uva.org/lib/boekhout.dutch.html)

Greater Toronto Area Combined Forces Special Unit. 2002. *Fact Sheet – Heroin*. (Available online at: www.cfseu.org/heroin.html)

Greene, J. and V. Schiraldi. 2002. *Cutting Correctly : New Prison Policies for Times of Fiscal Crisis*. Washington (D.C.) : The Justice Policy Institute. (Available online at: www.cjcj.org)

Grinspoon, L. and J.B. Bakalar. 1997. *Marijuana. The Forbidden Medicine*. New Haven and London : Yale University Press.

Gurley, R.J., Aronow, R. and M. Katz. 1998. « Medicinal marijuana : A comprehensive review. ». *Journal of Psychoactive Drugs*. 30(2) : 139.

Hall, W. 1987. « A simplified logic of causal inference ». *Australian and New Zealand Journal of Psychiatry*. 21 : 507-513.

Hall, W. and N. Solowij. 1998. « Adverse effects of cannabis ». *The Lancet*. 352(9140) : 6

Hamel, D. et. al. 2001. *Perceptions de la population québécoise en lien avec les programmes de prévention de la toxicomanie et du VIH*. Quebec City : Institut national de santé publique du Québec.

Hanak, C. et. al. 2002. «Cannabis, mental health and dependence. » in Pelc, I. (ed.). 2002. *International Scientific Conference on Cannabis*. Brussels.

Haney, M. et. al. 1999. « Abstinence symptoms following smoked marijuana in humans » *Psychopharmacology*. 141 : 395-404.

Hansard, House of Commons, July 10, 1908.

Hansard, House of Commons, January 26, 1911.

Hansard, House of Commons, April 23, 1923.

Hansard, House of Commons, 1932.

Hansard, House of Commons, February 24, 1938.

Hansard, Senate, February 24, 1955.

Hansard, Senate, June 23, 1955.

Hansard, House of Commons, May 30, 1961.

Hansard, House of Commons, June 7, 1961.

Hansard, House of Commons, March 27, 1969.

Hansteen, R.W, et. al. 1976. « Effects of cannabis and alcohol on automobile driving and psychomotor tracking ». *Annals of the New York Academy of Science*. 282 : 240-256.

Hartel, C.R. 1999. « Therapeutic Uses of Cannabis and Cannabinoids. » in Kalant, H. (ed.). 1999. *The Health Effects of Cannabis*. Toronto : Addiction Research Foundation.

Hathaway, A. D. 1997. « Marijuana and lifestyle : Exploring tolerable deviance. » *Deviant Behavior : An Interdisciplinary Journal*. 18 : 213-232.

Hathaway, A. D. 1997. « Marijuana and tolerance : Revisiting Becker's sources of control. » *Deviant Behavior : An Interdisciplinary Journal*. 18 : 103-124.

Hathaway, A.D. 2001. *Cannabis effects and dependency concerns in long-term frequent users : a missing piece of the public health puzzle*. (Brief submitted to the Senate Special Committee on Illegal Drugs. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Hawkins, D.J., Arthur, M.W. and R.F. Catalano. 1995. « Preventing Substance Abuse. ». in Tonry, M. and D.P. Farrington (eds.). 1995. *Building a Safer Society : Strategic Approaches to Crime Prevention*. Chicago : University of Chicago Press.

Health and Welfare Canada. 1990. *Straight facts about drugs & drug abuse*. Ottawa : Department of Supply and Services.

Health Canada. 1996. *Evaluation of Health Canada's Contributions to Canada's Drug Strategy: Final Report*. Ottawa : Canada.

Health Canada. 1997. *Evaluation of Canada's Drug Strategy: Final Report*. Ottawa : Canada.

Health Canada. 1999. *Research Plan for Marijuana for Medicinal Purposes : A Status Report*. Ottawa : Canada.

Health Canada. 2000. *Minister Rock announces intention to develop new approach for the use of marihuana for medical purposes.* Ottawa. News Release. September 14, 2000.

Health Canada. 2001. *Marijuana Medical Access Regulations - Regulatory Impact Analysis Statement*. Ottawa : Canada.

Health Canada. 2001. *Marijuana Medical Access Regulations – Amendments Resulting from Public Consultations*. Ottawa : Canada.

Health Canada. 2001. *Medical Access to Marijuana – How the Regulations Work.* Ottawa : Canada.

Henrion, R. 1995. *Rapport de la Commission de réflexion sur la drogue et la toxicomanie.* (Rapport au ministère des Affaires sociales, de la Santé et de la Ville). Paris : La Documentation française.

Home Affairs Committee. 2001. *Evidence to Home Affairs Committee Inquiry into Drug Policy*. London : House of Commons (United Kingdom). (Available online at: http://www.drugscope.org.uk/druginfo/evidence-select/evidence.htm)

House of Lords. 1998. *Ninth Report – Cannabis: The Scientific and Medical Evidence.* London : Select Committee on Science and Technology.

House of Lords. 2001. *Second Report – Therapeutic Uses of Cannabis.* London : Select Committee on Science and Technology.

Huestis, M.A. et. al. 1992. «Characterization of the absorption phase of marijuana smoking.» *Clinical Pharmacology and Therapeutics.* 52 : 31-41.

Inciardi, James A. 1986. *The War on Drugs: Heroin, Cocaine, Crime, and Public Policy*. Palo Alto (California) : Mayfield Publishing Company.

Inglis, B. (1975) *The Forbidden Game: A Social History of Drugs.* Londres: Hodder and Stoughton

INSERM. 2001. *Cannabis : Quels effets sur le comportement et la santé ?* Paris : Les Éditions Inserm.

International Narcotics Control Board. 1988. *Report of the International Narcotics Control Board for 1987.* Vienna : United Nations.

International Narcotics Control Board. 2002. *Report of the International Narcotics Control Board for 2001*. Vienna : United Nations.

Institute of Medicine. 1982. *Marihuana and Health.* Washington (D.C.) : National Academy of Sciences.

Jackson, A.Y. 2002. *The Costs of Drug Abuse and Drug Policy.* Ottawa : Library of Parliament – Parliamentary Research Branch. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Jeffery, W.K. et. al. 1996. « The involvement of drugs in driving in Canada : An update to 1994. ». *Can. Soc. Forens. Sci. J.* 29 (2) : 93-98.

Johnston, L.D. et. al. 2001. *Monitoring the future. National Survey Results of Drug Use, 1975-2000. Volume II College Students and Young Adults Ages 19-40.* Bethseda (Michigan) : NIDA.

Joseph Rowntree Foundation. 2000. *Drugs: dilemmas, choices and the law.* York : Joseph Rowntree Foundation. (Available online at: http://www.jrf.org.uk/knowledge/findings/foundations/N70.asp)

Joy, J.E., Watson, S.J. and J.A. Benson. 1999. *Marijuana and Medicine : Assessing the Science Base.* Washington (D.C.) : Institute of Medicine.

Kandel, D. and M. Davies. 1992. « Progression to regular marijuana involvement: Phenomenology and risk factors for near daily use ». in Glantz, M. and R. Pickens (eds.). 1992. *Vulnerability to Drug Abuse.* Washington (D.C.) : American Psychological Association. pp. 211-253.

Kandel, D. et. al. 1997. « Prevalence and demographic correlates of symptoms of last year dependence on alcohol, nicotine, marijuana and cocaine in the US population ». *Drugs, Alcohol and Dependency.* 44 : 11-29.

Keh, D.I. 1996. *Drug Money in a Changing World. Economic Reform and Criminal Finance.* Vienne : UNDCP (Technical paper nº 4.).

Keizer, Robert. 2001. *The Netherland's Drug Policy.* Brief submitted to the Senate Special Committee on Illegal Drugs.

Kilmer, B. 2002. «Do cannabis possession laws influence cannabis use ? ». in Pelc, I. (dir.). 2002. *International Scientific Conference on Cannabis.* Bruxelles.

King, A.J.C. et. al. 1999. *Trends in the health of Canadian youth.* Ottawa : Health Canada.

Kokoreff, Michel. 2001. *Drug Policy in France: From Criminalization to Risk Reduction.* Brief submitted to the Senate Special Committee on Illegal Drugs.

Kopp, P. and C. Palle. 1999. « Économistes cherchent politique publique efficace. » in Faugeron, C., (ed.). 1999. *Les drogues en France.* Paris : Georg.

Kopp, P. and P. Fenoglio. 2000. *Le coût social des drogues licites (alcool et tabac) et illicites en France.* Paris : OFDT.

Kosten, T.R. et. al. 1987. « Substance-use disorders in DSM-III-R ». *British Journal of Psychiatry.* 151 : 8-19.

Kouri, E.M. et. al. 2000. «Abstinence symptoms during withdrawal from chronic marijuana use ». *Experimental and Clinical Psychopharmacology.* 8 : 483-492.

Krajewski, Krzysztof. 1999. «How flexible are the United Nations drug conventions? ». *International Journal of Drug Policy.* 10 : 329-338.

Kušević, Vladimir. 1977. « Drug Abuse Control and International Treaties ». *Journal of Drug Issues.* 7(1) : 35-53.

Labrousse, A. and A. Wallon. 1993. *La Planète des drogues : organisations criminelles, guerres et blanchiment.* Paris : Seuil

Labrousse, A. 1998. « L'approvisionnement des marchés des drogues dans l'espace Schengen. » *Les Cahiers de la Sécurité Intérieure.* 32.

Labrousse, A. 2000. *Drogues. Un marché de dupes.* Paris : Éditions alternatives.

Labrousse, A. and L. Romero. 2001. *Rapport sur la situation du cannabis dans le RIF marocain.* Paris : OFDT.

Lafrenière, G. 2001. *National Drug Policy: United Kingdom.* Ottawa : Library of Parliament – Parliamentary Research Branch. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Lafrenière, G. 2001. *National Drug Policy: Sweden.* Ottawa : Library of Parliament – Parliamentary Research Branch. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Lafrenière, G. 2001. *Police Powers and Drug-Related Offences.* Ottawa : Library of Parliament – Parliamentary Research Branch (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Landry, Michel. 2001. *The Impact of Treatments Offered to Addicts in Quebec.* Brief submitted to the Senate Special Committee on Illegal Drugs.

Leduc, D., Miller-Chenier, N. and S. Norris. 2001. *Inventory of Federal Research on Illegal Drugs and Related Issues.* Ottawa : Library of Parliament – Parliamentary Research Branch. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Leduc D., Miller Chenier, N. et S. Norris. 2002. *Inventory of Provincial and Territorial Research on Illegal Drugs and Related Issues.* Ottawa : Library of Parliament – Parliamentary Research Branch. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Léger Marketing. 2002. *An Exploratory Study Among Canadians About the Use of Cannabis.* Montreal : Léger Marketing. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Leiter, Richard A. (dir.). 1999. *National Survey of State Laws.* Detroit : Gale Group. (Third Edition)

Leland M. Goodrich. 1960. « New Trends in Narcotics Control », *International Conciliation*, nº 530

Letter from Ms Kathy Bedard, Prince Rupert, British Columbia, May 15, 2002.

Lipton, D.S. 1995. *The Effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision.* Washington (D.C.) : National Institute of Justice.

Lowes, P.D. 1966. *The Genesis of International Narcotics Control.* Genève : Droz.

Luna, E.G. 1997. « Our Vietnam: The Prohibition Apocalypse », *Depaul L. Rev.* 46 : 483.

MacCoun, R., Reuter, P. and T. Schelling. 1996. « Assessing alternative drug control regimes. » *Journal of Policy Analysis and Management.* 15 (3).

MacDonald, Roederick A. 2002. *The Governance of Human Agency.* Montreal : McGill University – Professor of Constitutional Law. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

MacFarlane, B. A., Frater, R. J. and C Proulx. 1996. *Drug Offences in Canada.* Ontario : Canada Law Book.

MacKay, R. 2001. *National Drug Policy: Australia.* Ottawa : Library of Parliament – Parliamentary Research Branch. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Mackenzie King, William L. 1908.*The Need for the Suppression of the Opium Traffic in Canada.* Ottawa : House of Commons (Sessional Paper 36b).

MacPhee, D. 1999. « Effects of marijuana on cell nuclei », in Kalant, H. et. al. (eds.). 1999. *The Health Effects of Cannabis*, Toronto : Addiction Research Foundation.

Maillet A. and C. Cloutier-Vautour. 2002. Brief submitted to the Senate Special Committee on Illegal Drugs. Moncton.

Malherbe, J.F. 2002. *The Contribution of Ethics in Defining Guiding Principles for a Public Drug Policy.* Sherbrooke : University of Sherbrooke – Professor – *Applied Ethic Chair.* (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Mangham, Colin. 2001. *Implications of a Liberalized Drug Policy in Canada.* Brief submitted to the Senate Special Committee on Illegal Drugs. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Martineau, H. and É. Gomart. 2000. *Politiques et expérimentations sur les drogues aux Pays-Bas.* Rapport de synthèse???. Paris : OFDT.

Matsuda, L.A. et. al. 1990. «Structure of a cannabinoid receptor and functional expression of the cloned DNA ». *Nature.* 346(6284) : 5561-564.

McAllister, W.B. 1992. « Conflicts of Interest in the International Drug Control System », in William O. Walker III, (ed.). 1992. *Drug Control Policy: Essays in Historical and Comparative Perspective*, University Park (Pennsylvanie) : Pennsylvania State University Press.

McAllister, W.B. 1999. *Drug Diplomacy in the Twentieth Century : An international history.* London : Routledge.

McCaffrey, B.R. 1999. *Remarks before the First Annual Criminal Justice and Substance Abuse Conference.* Albany (New York). June 29, 1999.

McDonald, D. et. al. 1994. *Legislative Options for Cannabis Use in Australia.* Commonwealth d'Australie. (Available online at: http://www.druglibrary.org/schaffer/Library/studies/aus/cannabis.htm)

McKim, W.A. 2000. «Cannabis ». in McKim, W.A. (ed.). 2000. *Drugs and Behavior. An introduction to behavioral pharmacology.* Upper Saddle River : Prentice Hall.

McNamara, J. D. 1999 « When Cops Become the Gangsters ». *Los Angeles Times.* September 21, 1999. (Available online at: www.nakedgov.com/mcnamara.htm)

McNamara, J.D. 2000. « Commentary : Criminalization of Drug Use ». *Psychiatric Times.* 17(9).

Mechoulam, R. and Y. Gaoni. 1965. «A total synthesis of delta-9-tetrahydrocannabinol, the active constituent of hashish. ». *Journal of the American Chemistry Society*, 87 : 3273-3275.

Meier, Kenneth J. 1994. *The Politics of Sin: Drugs, Alcohol and Public Policy*. Armonk (New York) : M.E. Sharpe.

Mercer, W.G. and W.K. Jeffery. 1995. « Alcohol, Drugs and Impairment in Fatal Traffic Accidents in British Columbia » *Accid. Anal. And Prev.* 27(3) : 335-343.

Mewett, A. W. and S. Nakatsuru. 2000. *An Introduction to the Criminal Process in Canada*. Scarborough : Carswell (Fourth Edition).

Miles, G.C. et. al. 1974. *An Experimental Study of the Effects of Daily Cannabis Smoking on Behavioural Patterns*. Toronto : Addiction Research Foundation.

Miller, M. and G. Draper. 2001. *Statistics on Drug Use in Australia 2000*. Canberra : Australian Institute of Health and Welfare. (Available online at: http://www.aihw.gov.au/publications/phe/sdua00/index.html)

Ministerial Council on Drug Strategy. 1998. *National Drug Strategic Framework 1998-99 to 2002-03: Building Partnerships*. Canberra : Report prepared for the *Ministerial Council by a joint committee of the Intergovernmental Committee on Drugs and the Australian National Council on Drugs*. (Available online at: http://www.health.gov.au/pubhlth/nds/resources/publist.htm)

Ministerial Council on Drug Strategy. 2001. *National Action Plan on Illicit Drugs, 2001 to 2002-03*. Canberra : Report prepared for the *National Expert Advisory Committee on Illegal Drugs*. (Available online at: http://www.health.gov.au/pubhlth/nds/resources/publist.htm)

Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT). 1999. *Plan triennal de lutte contre la drogue et de prévention des dépendances (1999-2001)*. (Available online at: http://www.drogues.gouv.fr/uk/what_you_need/whatyouneed_intro.html.)

Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT). 1999. «Livret de connaissances, Synthèse du plan gouvernemental de lutte contre la drogue et de prévention des dépendances 1999-2000-2001 ». *Drogues : savoir plus, risquer moins*. MILDT (Available online at: http://www.drogues.gouv.fr/fr/index.html.)

Moreau de Tours, J. 1845. *Du haschich ou de l'aliénation mentale, étude psychologique*. Paris : Masson.

Moskowitz, H. 1985. « Marihuana and Driving ». *Accid. Anal. Prev.* 17 (4) : 323-345.

Munro, S. et. al. 1993. « Molecular characterization of a peripheral receptor for cannabinoids. ». *Nature*. 365 : 61-65.

Murphy, E. 1920. « The underground system. » *Maclean's*. 15 mars 1920.

Murphy, E. 1922. *The Black Candle*. Toronto : Thomas Allans.

Musto, D.F. 1999. *The American Disease: Origins of Narcotic Control*. Oxford: Oxford University Press (Third Edition)

National Drug Monitor. 2000. *Fact Sheet: Cannabis Policy. Update 2000.* Utrecht : Trimbos-Instituut.

National Drug Research Institute and Curtin University of Technology. 2000. *The Regulation of Cannabis Possession, Use and Supply.* Perth (Western Australia) : Working Paper for the *Drugs and Crime Prevention Committee – Parliament of Victoria.*

National Institute of Public Health. 2001. *National Report : Sweden 2001.* Stockholm.

Nelson, P.L. 1993. « A critical review of the research literature concerning some biological and psychological effects of cannabis » in Advisory Committee on Illicit Drugs (eds.) 1993. *Cannabis and the law in Queensland : A discussion paper.* Brisbane : Criminal Justice Commission of Queensland.

Nolin, P.C. 1998. *Foreword.* in Riley, D. 1998. *Drugs and Drug Policy in Canada : A Brief Review and Commentary.* Ottawa : Senate of Canada.

Noll, Alfons. 1977. «Drug abuse and penal provisions of the international drug control treaties ». *Bulletin on Narcotics.* 29(4) October/December 1977 : 41-57.

Observatoire français des drogues et des toxicomanies (OFDT). 2000. *Drogues et toxicomanies : Indicateurs et tendances.* Issue of 1999. (Available online at: http://www.drogues.gouv.fr/fr/index.html)

Observatoire français des drogues et des toxicomanies. 2002. *Drogues et dépendances: Indicateurs et tendances 2002.* Paris : OFDT.

Observatoire géopolitique des drogues. 1996. *Atlas mondial des drogues.* Paris : PUF.

Observatoire géopolitique des drogues. 1999. *Rapport annuel 1998/1999.* Paris : OGD.

Office of the Auditor General of Canada. 2001. *Report of the Auditor General of Canada – Chapter 11 – Illicit Drugs: The Federal Government's Role.* Ottawa : Department of Public Works and Government Services.

Office fédéral de la police. *Un aperçu de l'OFP.* (Available online at: http://www.bap.admin.ch/f/index.htm)

Office fédéral de la police. 1996. *Exploitation définitive de la banque de données en matière de drogue DOSIS*. 26 June 1996. (Available online at: http://www.bap.admin.ch/f/index.htm)

Office fédéral de la police. 2001. *Situation Suisse : Rapport de situation 2000* Bern : Service d'analyse et de prévention. (Available online at: http://www.bap.admin.ch/f/index.htm)

Office fédéral de la santé publique. 1998. *Mesures fédérales pour réduire les problèmes de la drogue.* Document de base de l'Office fédéral de la santé publique – Décision du Conseil fédéral du 20 février 1991. Doc. n° 3.4.1f.

Office fédéral de la santé publique. 1998. *Programme de mesures de santé publique de la Confédération en vue de réduire les problèmes de drogue.* (ProMeDro). 1998-2002.

Office fédéral de la santé publique. 2000. *La politique en matière de drogue*. September 2000. (Available online at: http://www.bag.admin.ch/sucht/f/index.htm)

Office of National Drug Control Policy. 2001. *National Drug Control Budget Executive Summary, Fiscal Year 2002*. Washington (D.C.) : The White House.

Office of National Drug Control Policy. 2002. *National Drug Control Strategy*. Washington (D.C.) : The White House.

Office of National Drug Control Policy. 2002. *National Drug Control Strategy: 2001 Annual Report*. Washington (D.C.) : The White House.

Organisation mondiale de la santé. 1952. *Comité d'experts des drogues susceptibles d'engendrer la toxicomanie*, Série des rapports techniques, n° 57. Quoted in Caballero, F. et Y. Bisiou. 2000. *Droit de la drogue*. Paris : Dalloz (Second Edition).

Organisation mondiale de la santé. 1964. *Comité d'experts des drogues engendrant la dépendance*, Série de rapports techniques, n° 273, Quoted in Caballero, F. and Y. Bisiou. 2000. *Droit de la drogue*. Paris : Dalloz (Second Edition).

Organisation mondiale de la santé. 1969. *Comité d'experts de la pharmacodépendance*. Série de rapports techniques. n° 407. Quoted in Caballero and Bisiou. 2000. *Droit de la drogue*. Paris : Dalloz.

Patten, D., et. al. 2000. *Substance Use among High School Students in Manitoba*. Winnipeg : Addictions Foundation of Manitoba.

Patton, D. et. al. 2001. *Substance use among Manitoba high school students*. Winnipeg : Addictions Foundation of Manitoba. (Available online at: www.afm.mb.ca)

Pays-Bas. 1985. *Groupe de travail interministériel sur les drogues et l'alcool*. La Haye : Ministère de la Justice.

Peith, M. 2001. *« Compatibilité de différents modèles de dépénalisation partielle du cannabis avec les conventions internationales sur les stupéfiants. »*. Avis juridique soumis à la demande de l'Office fédéral de la santé publique de la Confédération helvétique.

Pelletier, M. 1978. *Rapport de la mission d'étude sur l'ensemble des problèmes de la drogue*. Paris : La Documentation française.

Pernanen, K. et. al. 2002. *Proportions of crimes associated with alcohol and other drugs in Canada*. Ottawa : Canadian Center on Substance Abuse.

Pires A.P. 2002. *La politique législative et les crimes à « double face » : Éléments pour une théorie pluridimensionnelle de la loi criminelle*. Ottawa : University of Ottawa - Professor of Criminology. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Plecas, D., Dandurand, Y., Chin, V. and T. Segger. 2002. *Marihuana Growing Operations in British Columbia – An Empirical Survey (1997-2000)*. Department of Criminology and Criminal Justice – University College of the Fraser Valley and International Centre for Criminal Law Reform and Criminal Justice Policy.

Polen, M.R. 1993. «Health care use by frequent marijuana smokers who do not smoke tobacco.». *Western Journal of Medicine.* 158 : 596-601.

Police Foundation. 2000. *Drugs and the Law : Report of the Independent Inquiry into the Misuse of Drugs Act 1971.* London : The Police Foundation.

Popper, K. 1978. *Logique de la découverte scientifique.* Paris : Payot.

Popper, K. 1985. *La connaissance objective.* Bruxelles : Complexe.

Poulton, R., et. al. 2001. «Persistence and perceived consequences of cannabis use and dependence among young adults : Implications for policy ». *New Zealand Medical Journal.* 114 : 13-16.

Progressive Conservative Caucus Services, Briefing Note, June 1st, 1987.

Ramaekers, J.G. et. al. 2002. « Performance impairment and risk of motor vehicle crashes after cannabis use » in Pelc, I. (ed.). 2002. *International Scientific Conference on Cannabis*, Bruxelles.

Real Women of Canada. 2002. Brief submitted to the Senate Special Committee on Illegal Drugs. (Windsor, Ontario)

Rehm, J. 2001. *The Costs of public policies to fight illegal drugs.* Brief submitted to the Senate Special Committee on Illegal Drugs.

Reinarman, C. and H. G. Levine (dir.). 1997. *Crack in America: Demon Drugs and Social Justice.* Berkeley : University of California Press.

Reuband, K.. 1995. «Drug use and drug policy in Western Europe.» *European Addiction Research.* 1 : 32-41.

Reynaud, M., Parquet, P.J., et G. Lagrue (1999) *Les pratiques addictives. Usage, usage nocif et dépendance aux substances psychoactives.* Paris : Secrétariat d'État à la Santé et aux Affaires Sociales.

Rickard, M. 2001. *Reforming the Old and Refining the New: A Critical Overview of Australian Approaches to Cannabis.* Canberra: Department of the Parliamentary Library – Information and Research Services. Research paper nº 6 2001-02. (Available online at: http://www.aph.gov.au/library)

Rigter, H. and M. von Laar. 2002. «The Epidemiology of cannabis use.» in Pelc, I. (ed.). 2002. *International Scientific Conference on Cannabis.* Bruxelles.

Riley, D. 1996. *Harm Reduction : Concepts and Practice. A Policy Discussion Paper.* Ottawa: Canadian Center on Substance Abuse.

Riley, D. 1998. *Drugs and Drug Control Policy in Canada : A Brief Review and Commentary.* Ottawa : Senate of Canada

Roberts, G. and A. Ogborne. 1998. *Profile: Substance Abuse, Treatment and Rehabilitation in Canada.* Ottawa : Health Canada.

Robert, G. and A, Ogborne. 1999. *Best practices: Substance abuse, Treatment and Rehabilitation.* Ottawa : Health Canada.

Roberts, G. et. al. 2001. *Preventing substance use problems among young people : A compendium of best practices.* Ottawa : Health Canada.

Robson, William. 2002. « How many 'burbs must the drug war burn, before we call it a bust? » *Ottawa Citizen*, May 17, 2002.

Rodriguez de Fonseca, F. et. al. 1994. «Down regulation of rat brain cannabinol binding sites after chronic delta-9-THC treatment ». *Pharm. Biochem. Behav.* 47 : 33-40.

Roques, B. 1999. *La dangerosité des drogues.* Paris : Odile Jacob.

Rosenthal, M.S. and H.D. Kleber. 1999. «Making Sense of Medical Marijuana. » *Proceedings of the Association of American Physicians.* 111(2) : 159.

Royal Canadian Mounted Police. 1999. *Annual Report.* Ottawa : Canada.

Royal Canadian Mounted Police. 2000. *Drug Situation - Canada (1999).* Ottawa : Criminal Intelligence Directorate – RCMP.

Royal Canadian Mounted Police. 2002. *Drug Situation - Canada (2001).* Ottawa : Criminal Intelligence Directorate – RCMP.

Royal Commission of Inquiry into the Non-Medical Use of Drugs South Australia. 1979. *Final Report.* Adelaïde : South Australian Government.

Russo, E.B. 2002. « The role of cannabis and cannabinoids in pain management. » in Weiner, R.S. (ed.) 2002. *Pain Management. A Practical Guide for Clinicians.* Boca Raton, London, New York, Washington : CRC Press.

Russo, E.B., et. al. 2002. « Chronic cannabis use in the compassionate investigational new drug program : An examination of benefits and adverse effects of legal clinical cannabis. » *Journal of Cannabis Therapeutics.* 2(1) : 45.

Rydell, C. P. and S. S. Everingham. 1994. *Controlling Cocaine: Supply vs. Demand Programs.* RAND : Santa Monica (California).

Schiraldi, V., Holman, B. and P. Beatty. 2000. *Poor Prescription: The Costs of Imprisoning Drug Offenders in the United States.* Washington, D.C. : Justice Policy Institute. (Available online at: www.cjcj.org)

Scholten, W.K. 2002. « Medicinal cannabis : A quick scan on the therapeutic use of cannabis ». in Pelc, I., (ed.) 2002. *International Scientific Conference on Cannabis.* Bruxelles.

Senate Standing Committee on Legal and Constitutional Affairs. 1996. *Eleventh Report : Bill C8 : The Controlled Drugs and Substances Act.* Ottawa : Senate of Canada.

Setbon, M. 2000. *L'injonction thérapeutique : Évaluation du dispositif légal de prise en charge sanitaire des usagers de drogues interpellés.* Paris : Observatoire français des drogues et des toxicomanies

Sherman, L.W. et. al. 1997. *Preventing Crime : What Works, What Doesn't, What's Promising.* (A Report to the United States Congress). Washington (D.C.) : US Department of Justice.

Simmat-Durand, L. 1999. « Les obligations de soins en France. » in Faugeron, C., (ed.). 1999. *Les drogues en France. Politiques, marchés, usages.* Paris : Georg.

Simmat-Durand, L. 2000. *La lutte contre la toxicomanie. De la législation à la réglementation.* Paris : L'Harmattan.

Single Convention on Narcotics Drugs, 1961, (CTS 1964/30), amended by the Protocol amending the Single Convention on Narcotics Drugs, 1961, (CTS 1976/48).

Single, E., et. al. 1996. *The Costs of Substance Abuse in Canada.* Ottawa : Canadian Center on Drug Abuse.

Single, E. and T. Rohl. 1997. *The National Drug Strategy: Mapping the Future.* Canberra : Report prepared by the *Ministerial Council on Drug Strategy.* (Available online at: http://www.health.gov.au/pubhlth/publicat/document/mapping.pdf)

Single, E., Christie P. and R. Ali. 2000. « The impact of cannabis decriminalization in Australia and the United States » *Journal of Public Health Policy.* 21(2) : 157-186. (Available online at: http://www.parl.gc.ca/37/1/parlbus/commbus/senate/Com-f/ille-f/presentation-f/single-f.htm)

Sinha, J. 2001. *The History and Development of the Leading International Drug Control Conventions.* Ottawa : Library of Parliament – Parliamentary Research Branch. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Smiley, A. 1999. « Marijuana : On-Road and Driving Simulator Studies » in Kalant, H. et. al., (ed). 1999. *The Health Effects of Cannabis.* Toronto : Addiction Research Foundation.

Smith, D.E. 1998. « Review of the American Medical Association Council on Scientific Affairs Report on Medical Marijuana. » *Journal of Psychoactive Drugs.* 30 : 127-136.

Spicer, L. 2002. *Historical and Cultural Uses of Cannabis and the Canadian "Marijuana Clash".* Ottawa : Library of Parliament – Parliamentary Research Branch. (Available online at: www.parl.gc.ca/illegal-drugs.asp)

Staatscourant. 1996. in Korf D.J. and H. Riper.1999. « Windmills in their Minds? Drug Policy and Drug Research in the Netherlands ». *Journal of Drug Issues* 29(3) : 451.

Statistics Canada. 1997. "Illicit Drugs and Crime in Canada". *Juristat.* Canadian Centre for Justice Statistics. Catalogue n° 85-002-XIE.

Statistics Canada. 1999. "Justice Spending in Canada", *Juristat.* Canadian Centre for Justice Statistics. Catalogue n° 85-002-XIE.

Statistics Canada. 1999. "Illicit Drugs and Crime in Canada" *Juristat.* Canadian Centre for Justice Statistics. Catalogue n° 85-002-XIE.

Statistics Canada. 2002. "Crime Statistics in Canada – 2001" *Juristat.* Canadian Centre for Justice Statistics. Catalogue n° 85-002-XIE.

Stewart, David P. 1990. «Internationalizing The War on Drugs: The UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances ». *Denver Journal of International Law and Policy*. 18(3) : 387-404.

Stuart, D. 1999. "The Unfortunate Dilution of Section 8 Protection," *Queens Law Journal*. 25 (1).

Substance Abuse and Mental Health Services Administration. 2001. *Summary of findings from the 2000 national household survey on drug abuse.* Washington (D.C.) : Department of Health and Social Services.

Swift, W. et. al. 2001. «Cannabis use and dependence among Australian adults : Results from the National Survey of Mental Health and Wellbeeing ». *Addiction*. 96 : 737-748.

Swiss Federal Office of Public Health. 1999. *The Swiss drug policy: A fourfold approach with special consideration of the medical prescription of narcotics*. Bern: SFOPH

Sweden. 2000. *Summary of the report The Crossroads from the Swedish Commission of Narcotic Drugs.* Stockholm: The Swedish Commission on Narcotic Drugs

Tashkin, D.P. et. al. 1997. « Heavy habitual marijuana smoking does not cause an accelerated decline in FEV1 with age : A longitudinal study». *American Journal of Respiratory Critical Care.* 155 : 141-148.

Taylor, A.C. 1969. *American Diplomacy and the Narcotics Traffic, 1900-1939: A Study in International Humanitarian Reform.* Durham (N.C.): Duke University Press

Taylor, Charles. 1998. *Les sources du moi : la formation de l'identité moderne.* Montreal : Boréal.

Taylor, F.M. 1988. « Marijuana as a potential respiratory tract carcinogen: A retrospective analysis of a community hospital population ». *Southern Medical Journal.* 81 : 1213-1216.

The Economist .2001. « Stumbling in the Dark ». 2001. *The Economist*. July 28 – August 3.

The Economist. 2001. « The Untouchables ». *Economist*. April 21, 2001. 359 (8218) : 49

Trautmann, C. 1990. *Lutte contre la toxicomanie et le trafic de stupéfiants.* Rapport au premier ministre. Paris : La Documentation française.

Tribunal fédéral. *L'organisation judiciaire en Suisse*. (Available online at: http://www.bger.ch/index.cfm?language=french&area=Federal&theme=system&page=content&maskid=195)

Trimbos-Instituut. 2000. *The Netherlands Drug Situation 2000.* Report to the EMCDDA. Utrecht : Trimbost Instuut.(Available online at: www.emcdda.org)

United Nations .1976. *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.* Done at Vienna on 20 December 1988. New York : United Nations.

United Nations Office for Drug Control and Crime Prevention. 1998. *Country Drug Profile : Sweden.* 1998. Vienna : UNDCP.

United Nations Office for Drug Control and Crime Prevention. 2000. *Demand Reduction: A Glossary of Terms.* Vienna : UNDCP.

United Nations Office for Drug Control and Crime Prevention. 2001. *World Drug Report 2001.* Oxford : Oxford University Press.

United States. 1972. *International Narcotics Control: A Source Book of Conventions, Protocols, and Multilateral Agreements, 1909-1971.* Washington (D.C.) : Bureau of Narcotics & Dangerous Drugs.

Valois, Donat. 1972. «La marijuana et le haschisch ne seront pas légalisés ». *Le Droit*. Ottawa. 1er août 1972.

Van Laar, M., et. al. 2001. *Nationale Drug Monitor. Jaarbericht 2001.* Utrecht : NDM Bureau.

Van Ree, Erik. 1999. « Drugs as a Human Right ». *International Journal of Drug Policy*. 10 : 89-98

Vitaro, F., Gosselin C. and A. Girard. 2002. *Évolution de la consommation d'alcool et de drogues chez les jeunes au Québec de 1987 à 1998 : constatations, comparaisons et pistes d'explication*. Montreal : Comité permanent de lutte à la toxicomanie.

Wacquant, L. 2000. *Les prisons de la misère.* Paris : Éditions Raisons d'agir.

Walker III, William O. 1989. *Drug Control in the Americas.* Albuquerque (Nouveau-Mexique) : University of New Mexico Press.

Walker III, William O. 1991. *Opium and Foreign Policy: The Anglo-American Search for Order in Asia, 1912-1954.* Chapel Hill (C. du N.) : University of North Carolina Press. p. 16-17, Lowes (1966) : 152-153.

Wasmeier, M., et. al. 2000. *Path analysis survey of substance use among Newfoundland and Labrador Adolescents. Marijuana / Haschich and Solvent use.* St John's : Memorial University of Newfoundland.

Wayne, H. and S. Wendy. 2000. « The THC content of cannabis in Australia : Evidence and implications.". *Australian and New Zealand Journal of Public Health.* 24 : 503-508.

Westlake, T.M. et. al. 1996. « Chronic exposure to delta-9-THC fails to irreversibly alter brain cannabinoid receptors. ». *Brain Research.* 544 : 145-149.

Wheelock, Barbara B. 2002. *Physiological and Psychological Effects of Cannabis: Review of the Research Findings.* Ottawa : Senate Special Committee on Illegal Drugs.

Wiesbeck, G.A., et. al. 1996. « An evaluation of the history of a marijuana withdrawal syndrome in a large population. » *Addiction,* 91(10) : 1573-1579.

Wisotsky, S. 1990. *Beyond the War on Drugs: Overcoming a Failed Public Policy.* Buffalo : Prometheus Books.

Woody G.E. et. al. 1993. « Severity of dependence: Data from the DSM-IV field trials » *Addiction.* 88 : 1573-1579.

World Health Organization. 1997. *Cannabis: A Health Perspective and Research Agenda.* Geneva : WHO. (Available online at: www.who.org)

Zimmer L., and J.P. Morgan. 2000. *Marijuana myths, marijuana facts : a review of the scientific evidence.* New York : Lindesmith Center.

II – WITNESSES QUOTED IN THE REPORT

Mohamed ben Amar, Professor, Pharmacology and Toxicology – University of Montreal, First Session, Thirty-seventh Parliament, June 11, 2001, Issue nº 4.

Line Beauchesne, Professor, Department of Criminology – University of Ottawa, Second Session, Thirty-sixth Parliament, October 16, 2000, Issue nº 1.

Patricia Bégin, Director, Research and Evaluation – National Crime Prevention Centre, First Session, Thirty-seventh Parliament, June 10, 2002, Issue nº 22.

Marie-Andrée Bertrand, Professor Emeritus of Criminology – University of Montreal, First Session, Thirty-seventh Parliament, April 23, 2001, Issue nº 1.

Hilary Black, Founder and Director – B.C. Compassion Club Society, First Session, Thirty-seventh Parliament, November 7, 2001, Issue nº 10.

Tim Boekhout van Solinge, Lecturer and Researcher in Criminology – Utrecht University, First Session, Thirty-seventh Parliament, November 7, 2001, Issue nº. 11.

Micheal J. Boyd, Chair of the Drug Abuse Committee and Deputy Chief of the Toronto Police Service – Canadian Association of Chiefs of Police, First Session, Thirty-seventh Parliament, March 11, 2002, Issue nº 14.

Neil Boyd, Professor, Department of Criminology – Simon Fraser University, Second Session, Thirty-sixth Parliament, October 16, 2000, Issue nº 1.

Serge Brochu, Professor and Director of the International Center for Comparative Criminology – University of Montreal, First Session, Thirty-seventh Parliament, December 10, 2001, Issue nº 12.

Bill Campbell, President – Canadian Society on Addiction Medicine, First Session, Thirty-seventh Parliament, March 11, 2002, Issue nº 14.

Mark Connolly, Director General, Contraband and Intelligence Services Directorate, Customs Branch – Canada Customs and Revenue Agency First Session, Thirty-seventh Parliament, October 29, 2001, Issue nº 8.

John Conroy, Barrister, First Session, Thirty-seventh Parliament, March 11, 2002, Issue nº 14.

Jean-Michel Coste, Director – French Monitoring Centre for Drugs and Drug Addictions, First Session, Thirty-seventh Parliament, October 1st, 2001, Issue nº 7.

Patricia Erickson, Researcher – Centre for Addiction and Mental Health, First Session, Thirty-seventh Parliament, May 14, 2001, Issue nº 2.

Julian Fantino, Chief – Toronto Police Service, First Session, Thirty-seventh Parliament, September 10, 2001, Issue nº 5.

Benedikt Fischer, Professor, Department of Public Health Sciences – University of Toronto, First Session, Thirty-seventh Parliament, September 17, 2001, Issue nº 6.

David Griffin, Canadian Police Association, First Session, Thirty-seventh Parliament, May 28, 2001, Issue nº 3.

Henry Haddad, President – Canadian Medical Association, First Session, Thirty-seventh Parliament, March 11, 2002, Issue nº 14.

Health Canada, First Session, Thirty-seventh Parliament, June 10, 2002, Issue nº 22.

Kash Heed, Vice Drugs Section – Vancouver Police Service, First Session, Thirty-seventh Parliament, November 7, 2001, Issue nº 10

Gary E. Johnson, Governor, State of New Mexico, First Session, Thirty-seventh, November 5, 2001, Issue nº 9.

Cal Johnston, Chief – Regina Police Service, First Session, Thirty-seventh Parliament, May 13 2002, Issue nº 16.

Harold Kalant, Professor Emeritus – University of Toronto, First Session, Thirty-seventh Parliament, June 11, 2001, Issue nº 4.

Perry Kendall, Health Officer – Province of British Columbia, First Session, Thirty-seventh Parliament, September 17, 2001, Issue nº 6.

Paul Kennedy, Senior Assistant Deputy Solicitor General, Policing and Security Branch – Solicitor General of Canada, First Session, Thirty-seventh Parliament, June 10, 2002, Issue nº 22.

Barry King, Former Chair of the Drug Abuse Committee and Chief of the Brockville Police Service – Canadian Association of Chiefs of Police, First Session, Thirty-seventh Parliament, March 11, 2002, Issue nº 14.

R.G. Lesser, Chief Superintendent – Royal Canadian Mounted Police, First Session, Thirty-seventh Parliament, October 29, 2001, Issue nº 8.

Gillian Lynch, Director General, Drug Strategy and Controlled Substances Programme – Health Canada, First Session, Thirty-seventh Parliament, June 10, 2002, Issue nº 22.

Mary Lynch, Director, Canadian Consortium for the Investigation of Cannabinoids – Dalhousie University, First Session, Thirty-seventh Parliament, June 11, 2001, Issue nº 4.

Nicole Maestracci, President – Interministerial Mission for the Fight against Drugs and Drug Addiction, First Session, Thirty-seventh Parliament, October 1st, 2001, Issue nº 7.

Colin Mangham, Director – Prevention Source B.C., First Session, Thirty-seventh Parliament, September 17, 2001, Issue nº 6.

Céline Mercier, Associate Professor, Department of Psychiatry – McGill University, First Session, Thirty-seventh Parliament, December 10, 2001, Issue nº 12.

Croft Michaelson, Director and Senior General Counsel, Strategic Prosecution Policy Section – Justice Canada, First Session, Thirty-seventh Parliament, June 10, 2002, Issue nº 22.

John P. Morgan, Professor of Pharmacology – City of New York Medical School, First Session, Thirty-seventh Parliament, June 11, 2001, Issue nº 4.

Dann Michols, Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch – Health Canada, First Session, Thirty-seventh Parliament, June 10, 2002, Issue nº 22.

Dale Orban, Canadian Police Association, First Session, Thirty-seventh Parliament, May 28, 2001, Issue nº 3.

Michel Perron, Executive Director – Canadian Centre on Substance Abuse, First Session, Thirty-seventh Parliament, June 10, 2002, Issue nº 22.

Senate of Canada, Proceedings of the Senate Special Committee on Illegal Drugs, First Session, Thirty-seventh Parliament, March-April 2001, Issue nº 1.

Senate of Canada, Proceedings of the Senate Special Committee on Illegal Drugs, First Session, Thirty-seventh Parliament, May 28, 2001, Issue nº 3.

Eric Single, Professor, Department of Public Health Sciences – University of Toronto, First Session, Thirty-seventh Parliament, May 14, 2001, Issue nº 2.

Diane Steber Büchli, Head, International Drug Affairs Unit – Swiss Federal Office of Public Health, First Session, Thirty-seventh Parliament, February 24, 2002, Issue nº 13.

Art Steinman, Executive Director – Alcohol-Drug Education Service, First Session, Thirty-seventh Parliament, November 7, 2002, Issue nº 10.

Ambros Uchtenhagen, Retired Professor – Addiction Research Institute, First Session, Thirty-seventh Parliament, February 4, 2002, Issue nº 13.

Mark Ware, Assistant Professor – McGill University, First Session, Thirty-seventh Parliament, May 31st 2002, Issue nº 18.

Mark Zoccolillo, Professor, Department of Psychiatry – McGill University, Second Session, Thirty-sixth Parliament, October 16, 2000, Issue nº 1.

Sénat Senate

CANADA

LE CANNABIS :

POSITIONS POUR UN RÉGIME DE POLITIQUE PUBLIQUE POUR LE CANADA

RAPPORT DU COMITÉ SPÉCIAL DU SÉNAT SUR LES DROGUES ILLICITES

VOLUME III : PARTIE IV ET CONCLUSIONS

PRÉSIDENT

PIERRE CLAUDE NOLIN

VICE-PRÉSIDENT

COLIN KENNY

SEPTEMBRE 2002

TABLE DES MATIÈRES

GLOSSAIRE DES PRINCIPAUX TERMES

INTRODUCTION **1**

PREMIÈRE PARTIE – ORIENTATIONS GÉNÉRALES **5**

CHAPITRE 1 – NOTRE MANDAT **7**
LIBELLÉ 7
ORIGINES 9
NOTRE COMPRÉHENSION 11

CHAPITRE 2 – NOS TRAVAUX **13**
DEUX PRINCIPES DE TRAVAIL 14
L'ÉTAT DES CONNAISSANCES 15
Le programme de recherche 19
Audiences de témoins experts 20
Le défi de la synthèse 22
TENIR COMPTE DES OPINIONS 23
INTERPRÉTER À LA LUMIÈRE DE PRINCIPES 24

CHAPITRE 3 – NOS PRINCIPES DIRECTEURS **25**
L'ÉTHIQUE, OU LE PRINCIPE DE L'AUTONOMIE RÉCIPROQUE 28
LA GOUVERNANCE : MAXIMISER L'ACTION DES INDIVIDUS 32
La gouvernance de la collectivité 34
La gouvernance de soi 36
Le rôle de la gouvernance 37
LE DROIT PÉNAL OU LES LIMITES DE L'INTERDICTION 38
Nécessité de la distinction 39
Critères de distinction 41
Application aux drogues illicites 45
LA SCIENCE OU LA CONNAISSANCE APPROCHÉE 46
CONCLUSIONS 51

CHAPITRE 4 – UN CONTEXTE EN MOUVANCE **53**
MUTATIONS DU CONTEXTE INTERNATIONAL 53
Globalisation et intégration 53
Errances d'un discours sécuritaire 57
Des politiques antidrogues aux politiques sur les drogues 59
MUTATIONS AU CANADA 61
L'activisme judiciaire 61
Une stratégie nationale de prévention du crime 62
La lutte au crime organisé 62
UN DÉBAT DE SOCIÉTÉ 63

PARTIE II – LE CANNABIS : EFFETS, USAGES, ATTITUDES **65**

CHAPITRE 5 – LE CANNABIS : DE LA PLANTE AU JOINT **67**
UNE PLANTE, DIVERSES DROGUES 68
ROUTES DU CANNABIS 72
PROPRIÉTÉS DU CANNABIS 79
Concentration en Δ^9THC 80
PHARMACOCINÉTIQUE 86
CONCLUSIONS 90

CHAPITRE 6 – USAGERS ET USAGES : FORMES, PRATIQUES, CONTEXTES **93**
TENDANCES D'USAGE 94
Consommation en population générale 95
Consommation chez les jeunes 99
Tendances d'usage dans d'autres pays 105
Éléments de synthèse 114
FORMES ET MODES D'USAGE 116
Le cannabis dans l'histoire 117
Trajectoires d'usages 119
Facteurs reliés à l'usage 125
Éléments de synthèse 131
UNE ESCALADE VERS D'AUTRES DROGUES ? 132
CANNABIS, VIOLENCE ET CRIMINALITÉ 134
CONCLUSIONS 136

CHAPITRE 7 – LE CANNABIS : EFFETS ET CONSEQUENCES **139**
EFFETS ET CONSÉQUENCES DU CANNABIS : CE QU'ON NOUS A DIT 142
EFFETS AIGUS DU CANNABIS 148
CONSÉQUENCES DE LA CONSOMMATION CHRONIQUE 152
Conséquences physiologiques de l'usage chronique 153
Conséquences cognitives et psychologiques 158
Conséquences comportementales et sociales 162
TOLÉRANCE ET DÉPENDANCE 163
Dépendance au cannabis 164
Sévérité de la dépendance 171
La tolérance 174
ÉLÉMENTS DE SYNTHÈSE 175
CONCLUSIONS 176

CHAPITRE 8 – CONDUITE SOUS L'EFFET DU CANNABIS **179**
MODES DE DÉPISTAGE 182
DONNÉES ÉPIDÉMIOLOGIQUES 187
Études hors contexte accidentel 188
Études en contexte accidentel 189
Enquêtes épidémiologiques auprès des jeunes 192
Évaluation du risque 192
ÉTUDES EXPÉRIMENTALES 195
Activités hors conduite 195
En activité de conduite 197
CONCLUSIONS 201

CHAPITRE 9 – APPLICATIONS THÉRAPEUTIQUES DU CANNABIS **203**
ASPECTS HISTORIQUES 208
CONNAISSANCES CONTEMPORAINES 210
Utilisations thérapeutiques 210
Le cannabis comme médicament ? 213
PRATIQUES THÉRAPEUTIQUES ACTUELLES 216
CONCLUSIONS 219

CHAPITRE 10 – OPINIONS ET ATTITUDES DES CANADIENS **221**
LES MÉDIAS 222
ENQUÊTES ET SONDAGES 227
ATTITUDES ET OPINIONS EXPRIMÉES AU COMITÉ 234
CONCLUSIONS 237

PARTIE III – POLITIQUES ET PRATIQUES AU CANADA **239**

CHAPITRE 11 – UNE STRATÉGIE CANADIENNE ANTIDROGUE ? **241**
PHASE I – ÉLABORATION ET MISE EN PLACE 242
Création du Centre canadien de lutte contre l'alcoolisme et les toxicomanies 248
Création du Secrétariat de la Stratégie canadienne antidrogue 250
PHASE II – RENOUVELLEMENT 252
PHASE III – LE RENOUVELLEMENT SANS FINANCEMENT PRÉCIS 255
LA STRATÉGIE CANADIENNE ANTIDROGUE – UNE RÉUSSITE ? 257
CONCLUSIONS 259

CHAPITRE 12 – LE CONTEXTE LÉGISLATIF NATIONAL **261**
1908-1960 : L'HYSTÉRIE 264
La Loi sur l'opium de 1908 269
Loi sur l'opium et les narcotiques de 1911 269
Les amendements à la Loi sur l'opium et les narcotiques (1920-1938) 272
Les modifications à la Loi sur l'opium et les narcotiques en 1954 281
Le rapport du Sénat de 1955 282
DE 1960 À LA COMMISSION LE DAIN : À LA RECHERCHE DES RAISONS PERDUES 286
La Loi sur les stupéfiants (1961) 286
La Loi sur les aliments et drogues et les barbituriques (1961) 288
La Commission Le Dain (1969-1973) 291
Le projet de loi S-19 et le cannabis 302

APRÈS LE DAIN : LA FUITE EN AVANT 303
La Loi réglementant certaines drogues et autres substances 305
CONCLUSIONS 315

CHAPITRE 13 – RÉGLEMENTER L'UTILISATION DU CANNBIS À DES FINS THÉRAPEUTIQUES 317
CADRE ENTOURANT LA RÉCENTE RÉGLEMENTATION 318
Article 56 – Loi réglementant certaines drogues et autres substances 318
Contestations fondées sur la Charte – utilisation de la marijuana à des fins thérapeutiques 320
Réaction du gouvernement 322
RÉGLEMENTATION SUR L'ACCÈS À LA MARIJUANA À DES FINS MÉDICALES 323
Autoristion de posséder 324
Licences de production 328
Autres dispositions 329
ACCÈS HUMANITAIRE ? 329
Admissibilité 330
Accès au cannabis 335
Produits 338
Coûts 338
POURSUIVRE LA RECHERCHE 340
Recherche scientifique 340
Marijuana propre à la recherche 343
CONCLUSIONS 344

CHAPITRE 14 – PRATIQUES POLICIÈRES 347
ORGANISMES D'EXÉCUTION DE LA LOI 347
GRC 347
L'Agence des douanes et du revenu du Canada 350
Polices municipales et provinciales 352
COÛTS 353
POUVOIRS POLICIERS 358
Fouilles perquisitions et saisies 360
La provocation policière et les activités illégales 374
Conclusion 379
STATISTIQUES 380
Incidents relatés 380
Accusations 383
Inquiétudes 386
La Loi sur les douanes – amendes 389
SAISIES 390
CONCLUSIONS 392

CHAPITRE 15 – LE SYSTÈME DE JUSTICE PÉNALE 393
POURSUITES 393
TRIBUNAUX 394
Les tribunaux de traitement de la toxicomanie 395
DÉCISION ET DÉTERMINATION DE LA SANCTION 399
SERVICE CORRECTIONNEL 402
CASIER JUDICIAIRE 406
CONTESTATIONS JUDICIAIRES 409
CONCLUSIONS 415

CHAPITRE 16 – PRATIQUES PRÉVENTIVES 417
DES ACTIONS QUI NE SONT PAS À LA HAUTEUR DES DISCOURS 421
On ne fait pas suffisamment de prévention 422
La prévention est insuffisamment ciblée 424
On ne fait pas suffisamment l'évaluation des mesures de prévention 426
Les messages sociaux contredisent les messages de prévention 427
Il existe une connaissance dont il faut s'inspirer 428
PRÉVENIR : QUOI ? COMMENT ? 429
RÉDUCTION DES RISQUES, RÉDUCTION DES MÉFAITS 441
CONCLUSIONS 443

CHAPITRE 17 – PRATIQUES DE SOINS 445
DÉPENDANCES AU CANNABIS 445
FORMES DE TRAITEMENT 451
L'EFFICACITÉ DES TRAITEMENTS 453
CONCLUSIONS 456

CHAPITRE 18 – OBSERVATIONS SUR LES PRATIQUES 457
DES DIFFICULTÉS D'ARTICULATION ENTRE LES ACTEURS 457
UN ARRIMAGE DIFFICILE ENTRE LES APPROCHES 459
DES COÛTS ÉCONOMIQUES ET SOCIAUX IMPORTANTS 462
CONCLUSIONS 467

PARTIE IV – OPTIONS DE POLITIQUE PUBLIQUE 469

CHAPITRE 19 – LE CONTEXTE JURIDIQUE INTERNATIONAL 471
ÉLÉMENTS DE GÉNÉALOGIE 472
La Conférence de Shanghai (1909) 475
La Convention internationale de l'opium de 1912 (La Haye) 477
Les Conventions de l'opium de Genève (1925) 479
La Convention de Genève pour limiter la fabrication et réglementer la distribution des stupéfiants (1931) / Accord de Bangkok sur la consommation d'opium (1931) 480
La Convention pour la répression du trafic illicite des drogues nuisibles (Genève, 1936) 482
La Deuxième Guerre mondiale 482
Le Protocole de Lake Success (1946) 483
Le Protocole de Paris (1948) 483
Le Protocole de l'opium de New York (1953) 484
LES TROIS CONVENTIONS ACTUELLES 485
La Convention unique sur les stupéfiants de 1961 485
Convention sur les substances psychotropes 490
Protocole portant amendement à la Convention unique sur les stupéfiants de 1961 496
Convention contre le trafic illicite de stupéfiants et de substances psychotropes 498
UNE MARGE DE MANŒUVRE? 501
CONCLUSIONS 504

CHAPITRE 20 – POLITIQUES PUBLIQUES DANS D'AUTRES PAYS 507
FRANCE 508
Des logiques distinctives 508
Une politique publique intégrée 510
Cadre législatif 513
Quelques rapports clés 516
Statistiques sur l'usage et la répression 520
Coûts 523
PAYS-BAS 524
Le pragmatisme néerlandais ? 525
Des rapports d'experts fondateurs 527
La législation 533
Le régime des coffee shops 536
Données sur l'usage 538
ROYAUME-UNI 542
Stratégie décennale de lutte contre la toxicomanie 542
Cadre législatif 543
Autres lois pertinentes au domaine de la toxicomanie 546
Débats au RU 547
Études et rapports récents 548
Administration 556
Coûts 556
Statistiques 558
LA SUÈDE 560
Stratégie nationale 562
Cadre législatif 566
Le débat en Suède 568
Rapports récents 569
Coûts 571
Administration 572
Statistiques 572
LA SUISSE 575
Une politique de réduction des risques 575
Évolution du régime juridique 583
Un projet de dépénalisation du cannabis 585
Administration de la politique suisse en matière de drogue 587
Statistiques sur l'usage de stupéfiants et les infractions à la LStup 589
L'AUSTRALIE 592
Stratégie nationale sur les drogues 592
Le cadre législatif 597
Décriminalisation du cannabis 601
Administration 603
Statistiques 605
LES ÉTATS-UNIS 607
Le cadre législatif de l'administration fédérale et des États 607
La législation actuelle et son application 610
Buts et objectifs de la politique fédérale de lutte contre les stupéfiants 619
Administration de la politique 622
Sujets d'actualité et débats 624
Statistiques 626

CHAPITRE 21 – OPTIONS DE POLITIQUE PUBLIQUE	**631**
L'INEFFICACITÉ DES POLITIQUES PÉNALES	**633**
Des impacts sur la consommation ?	**634**
Des impacts sur l'offre ?	**640**
Conclusion	**640**
ÉCONOMIE GÉNÉRALE D'UNE POLITIQUE PUBLIQUE SUR LE CANNABIS	**641**
COMPOSANTES D'UNE POLITIQUE PUBLIQUE	**644**
Un centre de responsabilité fort	**644**
Interconnexion	**645**
Élaboration en commun d'objectifs partagés	**645**
Des outils de connaissance	**645**
OPTIONS LÉGISLATIVES	**646**
Clarifications terminologiques	**646**
Critères pour une politique juridique sur le cannabis	**654**

CONCLUSIONS ET RECOMMANDATIONS	**659**
IL Y A TRENTE ANS, LEDAIN	**659**
L'INEFFICACITÉ DES PRATIQUES ACTUELLES	**661**
UNE POLITIQUE PUBLIQUE BASÉE SUR DES PRINCIPES DIRECTEURS	**663**
UNE STRATÉGIE FÉDÉRALE CLAIRE ET COHÉRENTE	**664**
UNE STRATÉGIE NATIONALE SOUTENUE PAR DES MOYENS ET DES OUTILS	**665**
UNE POLITIQUE DE SANTÉ PUBLIQUE	**667**
UNE APPROCHE RÉGLEMENTAIRE SUR LE CANNABIS	**670**
UNE APPROCHE DE COMPASSION POUR LES USAGES THÉRAPEUTIQUES	**671**
DISPOSITIONS SUR LA CONDUITE SOUS L'INFLUENCE DU CANNABIS	**672**
POURSUIVRE LA RECHERCHE	**673**
POSITIONNEMENT INTERNATIONAL DU CANADA	**674**

PROPOSITIONS DE MISE EN ŒUVRE DE LA RÉGLEMENTATION DU CANNABIS AUX FINS THÉRAPEUTIQUES ET RÉCRÉATIONNELLES	**676**
BIBLIOGRAPHIE	**681**

GLOSSAIRE DES PRINCIPAUX TERMES

Abus
Terme vague qui reçoit une grande variété de significations, selon les contextes sociaux, médicaux, et juridiques. Selon certains, tout usage de drogues illicites est un abus : ainsi, les conventions internationales considèrent l'usage de toute substance prohibée pour des fins autres que médicales ou scientifiques comme un abus. Le Manuel diagnostic de l'Association américaine de psychiatrie définit l'abus comme un mode d'utilisation inadéquat d'une substance conduisant à une altération du fonctionnement ou à une souffrance cliniquement significative, et suggère 4 critères (voir le chapitre 7 du rapport). Nous lui préférons le concept d'usage excessif (ou usage nocif).

Accoutumance *(de l'anglais addiction)*
Terme général renvoyant aux phénomènes de tolérance et de pharmacodépendance. Le terme accoutumance est rarement utilisé en français qui utilise plutôt le terme toxicomanie.

Addiction
Certains auteurs utilisent ce terme issu de l'anglais pour désigner le processus par lequel un comportement, pouvant permettre une production de plaisir et d'écarter une sensation de malaise interne, est employé de façon caractérisée par l'impossibilité répétée de contrôler ce comportement et sa poursuite en dépit de la connaissance de ses conséquences négatives. Ces auteurs le préfèrent au concept de dépendance, celui-ci ne permettant pas de travailler sur la période qui précède la dépendance. Nous lui préférons le terme dépendance.

Agoniste
Se dit entre autres d'une substance qui agit sur un récepteur pour produire certaines réponses.

Anandamide
Neurotransmetteur agoniste du système cannabinoïde endogène. Bien que les rôles spécifiques de ces neurotransmetteurs ne soient pas encore définis, ils semblent agir comme des neuromodulateurs ; en effet, le THC augmente la libération de dopamine du noyau accumbens et du cortex préfrontal.

Cannabinoïdes
Récepteurs endogènes des molécules actives du cannabis, notamment le THC. Deux récepteurs endogènes ont été identifiés : CB_1 existent en grande densité dans l'hippocampe, le ganglion basal, les corps cérébelleux, et le cortex cérébral et CB_2, ils sont particulièrement abondants dans le système immunitaire Les effets centraux du cannabis semblent être exclusivement reliés aux récepteurs CB_1.

Cannabis
Il existe trois variétés de plantes de cannabis, le *cannabis sativa*, le *cannabis indica*, et le *cannabis ruredalis*. La plante de la variété *cannabis sativa* est la plus répandue poussant dans presque tous les sols. La plante de cannabis est connue en Chine depuis environ 6000 ans. À partir des sommités florifères de la plante de cannabis, mais aussi parfois des feuilles, on obtient le tabac à fumer. Sous cette forme, l'appellation la plus courante est le pot, mais on le désigne aussi sous le nom de mari, herbe, dope, ganja. La résine extraite de la plante sert à fabriquer le haschich.

Généralement classifié sous les psychotropes, le cannabis est un perturbateur du système nerveux central. Le cannabis contient plus de 460 produits chimiques connus, dont plus de 60 sont désignés sous le nom de cannabinoïdes. Le principal ingrédient actif du cannabis est le delta-9-tétrahydrocannabinol, communément appelé THC. D'autres cannabinoïdes présents incluent le delta-8-tétrahydrocannabinol, le cannabinol et le cannabidiol mais ils sont présents en faibles quantités et n'exercent pas d'effets significatifs sur le comportement des individus, comparativement au THC. Ils peuvent cependant contribuer à moduler l'effet global du produit. Dans le rapport, nous utilisons le terme cannabis pour désigner l'ensemble des produits, et n'utilisons marijuana ou haschich que lorsque nous désignons ces dérivés spécifiquement.

Commission sur les drogues (CND)
La Commission sur les narcotiques a été créé en 1946 par le Conseil économique et social des Nations Unies. La Commission est le principal organisme d'élaboration de politiques sur les drogues au sein du système onusien. Elle examine la situation mondiale relativement à l'abus de drogues et fait des propositions pour renforcer le contrôle international des drogues.

Conduite (ou usage) à risque
Comportement d'usage qui met la personne à risque de développer des problèmes de dépendance à la substance. La conduite à risque se compose de l'interaction complexe entre au moins quatre facteurs : le contexte d'usage, la quantité consommée, la fréquence de la consommation et la durée et l'intensité de la consommation. (Nous proposons des critères à la conclusion du rapport).

Conventions internationales
Sous l'égide de la Société des Nations en 1908 puis des Nations Unies, diverses conventions internationales réglementent la possession, l'usage, la fabrication, la distribution, le commerce, etc., des substances psychotropes. Les trois principales conventions sont celles de 1961, 1971 et 1988. Le Canada a ratifié ces trois conventions. Ces conventions, dont l'application est assujettie aux lois constitutionnelles des signataires, établissent un système de réglementation où seuls les usages aux fins médicales et scientifiques sont permis. Ce système est axé sur la prohibition des plantes source (coca, opium et cannabis) et sur le contrôle des dérivés synthétiques fabriqués par les compagnies pharmaceutiques.

Décriminalisation
Opération consistant à retirer un comportement de la «compétence » du système de justice criminelle. On distingue habituellement entre *décriminalisation de droit (ou de jure)* impliquant une modification *législative* du Code criminel (ou de toute loi de nature criminelle)et *décriminalisation de fait (ou de facto)* où il s'agit d'une décision administrative de ne pas poursuivre le comportement qui demeure cependant illégal. La décriminalisation ne concerne que le Code criminel (ou toute loi de nature criminelle), et ne signifie pas que l'on retire la compétence du système juridique dans son ensemble. D'autres lois non criminelles peuvent réguler et contrôler le comportement qui a été décriminalisé (infractions civiles, réglementaires, etc.).

Déjudiciarisation
Réfère aux mesures alternatives à la poursuite ou à la condamnation pénale d'un acte qui demeure par ailleurs prohibé. La déjudiciarisation peut se faire avant la mise en accusation, par exemple si la personne inculpée consent à suivre un traitement. Elle peut aussi se faire au moment de la sanction, et prend alors la forme de sanctions de travail communautaire ou de traitement.

Demi-vie
Temps requis pour la diminution de moitié de la concentration d'une drogue dans le sang. La demi-vie d'élimination du THC est en moyenne de 4,3 jours. Suite au phénomène de tolérance métabolique, les consommateurs réguliers métabolisent et excrètent le produit plus rapidement que les usagers occasionnels. D'autre part, à cause de sa très grande liposolubilité, l'administration répétée du THC provoque son accumulation dans les graisses. Du fait de ce stockage graisseux, la demi-vie d'élimination tissulaire du THC peut atteindre 7 à 12 jours chez les consommateurs réguliers. La consommation prolongée du cannabis se traduit donc par une période d'élimination plus longue du THC. Ainsi, même après une semaine, 20 à 30 % du THC administré et ses métabolites demeurent dans l'organisme. Le THC et ses métabolites sont graduellement excrétés dans l'urine (environ un tiers) et dans les matières fécales (environ deux tiers). Des traces de THC ou de ses métabolites peuvent être détectées dans l'urine jusqu'à 30 jours après sa consommation

Dépénalisation
Opération consistant à modifier les peines (sanctions) associées à un acte dans le Code criminel. La dépénalisation signifie la plupart du temps le fait d'abroger les dispositions permettant une sanction d'incarcération.

Dépendance
État où l'usager de drogue continue de consommer même si l'usage entraine des problèmes qui peuvent être d'ordre physique, psychologique, relationnel, familial, ou social. La dépendance est un phénomène complexe qui peut avoir des composantes génétiques. La dépendance psychologique renvoie aux effets psychiques caractérisés par le désir insistant et persistant de consommer la drogue. La dépendance physique renvoie aux mécanismes d'adaptation de l'organisme à la consommation prolongée et peut s'accompagner d'une tolérance acquise. L'Association psychiatrique américaine propose 7 critères (voir chapitre 7).

Dopamine
Neuromédiateur impliqué notamment dans les mécanismes de perception du plaisir.

Drogue
Terme qui renvoie généralement aux substances illicites par opposition à d'autres substances telles l'alcool, la nicotine ou des médicaments psychotropes. En pharmacologie, le terme réfère à tout agent chimique qui modifie les processus biochimiques ou physiologiques des tissus ou de l'organisme. En ce sens, le terme drogue s'applique à toute substance qui est consommée principalement pour ses effets psychoactifs.

Effets aigus
Se dit des effets résultant de l'action ponctuelle d'un médicament et généralement des effets à court terme. Ces effets peuvent être centraux (sur les fonctions cérébrales) ou périphériques (sur le système nerveux).

Effets chroniques
Se dit des effets qui se développent avec le temps, à la suite de la prise ou de l'administration régulière d'une substance. Dans le rapport, nous avons préféré parler des conséquences de l'usage prolongé plutôt que d'effets chroniques.

Escalade (théorie de)
Théorie qui suggère une séquence progressive dans l'utilisation des drogues, nicotine, alcool, cannabis, puis les drogues « dures ». Elle repose sur une association statistique entre l'usage de drogues dures et le fait que ces personnes aient d'abord consommé du cannabis. Cette théorie n'a reçu aucune validation empirique et est tombée en désuétude.

Haschich
Résine issue de la plante de cannabis et transformée en pâte.

Intoxication
Perturbations qu'exerce une substance sur l'organisme. On distingue généralement quatre niveaux d'intoxication : légère, modérée, grave et mortelle.

Joint
Cigarette de marijuana, avec ou sans tabac. Le fait que deux cigarettes ne soient jamais identiques rend difficile l'analyse scientifique des effets du principe actif, notamment pour les études sur le cannabis thérapeutique.

Légalisation
Système de réglementation permettant la culture, production, fabrication, commercialisation, vente et usage de substances. Un système de légalisation peut être avec (réglementation) ou sans (libre marché) contrôles de l'État.

Liposolubilité
Propriété biophysique d'une substance de se répandre et se dissoudre plus ou moins facilement dans les graisses de l'organisme. Le THC est très liposoluble.

Marijuana
Nom mexicain qui désigne initialement une cigarette de mauvaise qualité. Par extension est devenu un équivalent pour désigner le cannabis.

Narcotique
Substance provoquant un état de torpeur ou un sommeil artificiel.

Observatoire européen des drogues et des toxicomanies (OEDT)
L'OEDT a été créé en 1993 pour apporter à la Communauté européenne et à ses États membres "des informations objectives, fiables et comparables au niveau européen sur le phénomène des drogues et des toxicomanies et leurs conséquences". Les informations statistiques, documentaires et techniques traitées ou produites par l'Observatoire fournissent à son audience une image d'ensemble sur le phénomène des drogues en Europe. L'Observatoire travaille uniquement dans le domaine de l'information. Il est composé d'un réseau de correspondants nationaux dans chacun des pays de l'Union.

Organe international de contrôle des stupéfiants (OICS)
L'Organe international de contrôle des stupéfiants (OICS ou Organe) est un organisme de contrôle indépendant et quasi-judiciaire chargé de l'application des conventions des Nations Unies sur les drogues; il a été créé en 1968 par la Convention unique sur les stupéfiants de 1961. Il a eu des prédécesseurs créés par les précédentes conventions sur les drogues, dès l'époque de la Société des Nations. L'organe est maintenant chargé de faire des recommandation à la

Commission sur les narcotiques relativement aux substances à placer dans les annexes des conventions.

Organisation mondiale de la santé (OMS)
Créée en 1948, l'OMS est l'agence des Nations Unis spécialisée dans les questions de santé. Son mandat est de favoriser le plus haut degré de santé possible. La santé est définie comme un état global de bien-être physique, psychologique et social et non seulement comme l'absence de maladie ou d'infirmité.

Office of national drug control policy (ONDCP) USA
Office national sur la politique de contrôle des drogues. Créé en 1984 sous la présidence Reagan, l'Office relève de la Maison Blanche. L'Office coordonne la politique américaine sur les drogues et gère un budget d'environ 18 milliards $ US par année.

Opiacé
Substance contenant de l'opium ou exerçant une action comparable à celle de l'opium.

Pharmacodépendance
Voir dépendance.

Porte d'entrée (théorie de la)
Aussi nommée théorie de l'introduction. Semblable à la théorie de l'escalade mais renvoie plus spécifiquement au fait que les personnes qui se procurent du cannabis viennent en contact avec des milieux potentiellement criminogènes du fait que le cannabis soit illégal.

Programme des Nations Unies pour le contrôle international des drogues (PNUCID)
Mieux connu sous l'acronyme anglais UNDCP. Fondé en 1991, le Programme a pour objectif d'informer le monde sur les dangers de l'abus de drogues. Le programme vise à renforcer l'action internationale contre la production, le trafic et la criminalité reliée aux drogues en proposant des programmes de développement alternatif, de monitoring des cultures et de lutte au blanchiment d'argent. Le programme d'évaluation globale veut aussi fournir des données fiables et le programme d'assistance juridique aide les pays à rédiger des lois adéquates ainsi qu'à former le personnel du système de justice. Le PNUCID relève du Bureau des Nations Unies pour le contrôle des drogues et la prévention du crime.

Prohibition
Terme issu historiquement de la prohibition de l'alcool aux États-Unis entre 1919 et 1933. Par extension, ce terme renvoie aux politiques poursuivies par les États et par les Nations Unies qui visent une société sans drogue. La prohibition est un système fondé sur l'interdiction de la fabrication et de l'usage de drogues à l'exception des usages scientifiques et médicaux.

Psychotrope
Substance qui agit sur le psychisme en modifiant le fonctionnement mental, entrainant des changements dans les perceptions, l'humeur, la conscience, le comportement et diverses fonctions psychologiques et organiques. De manière spécifique réfère aux médicaments utilisés dans le traitement de désordres mentaux, tels les neuroleptiques, les anxiolytiques, etc. Renvoie aux médicaments couverts par la Convention de 1971.

Réglementation
Système de contrôle qui précise les conditions sous lesquelles il est permis de fabriquer, produire, commercialiser, prescrire, vendre ou acheter une substance. La réglementation peut être axée sur la prohibition (comme c'est le cas actuellement pour les drogues illicites) ou sur l'accès contrôlé (comme pour les médicaments psychotropes et l'alcool). Notre proposition de régime d'exemption sous conditions repose sur une approche réglementaire.

Société des Nations (SDN)
Prédécesseur de l'ONU, la SDN était l'organisation internationale des états jusqu'en 1938.

Stupéfiant
Se dit souvent des substances dont les effets psychoactifs peuvent entraîner des effets de tolérance et de dépendance. Plus correctement, ce terme ne devrait s'utiliser que pour désigner les dépresseurs du système nerveux central tels les opiacés.

Substance psychoactive
Substance qui modifie les processus mentaux tels la pensée ou les émotions. Terme plus neutre que drogue, et qui ne distingue pas les substances selon leur statut juridique (licites, illicites) c'est celui que nous préférons utiliser dans le rapport.

Tétrahydrocannabinol (Δ9-THC)
Principal composant actif du cannabis, le Δ9-THC est très liposoluble, a une demi-vie d'élimination très longue, et ses effets psychoactifs sont modulés par les autres cannabinoïdes du cannabis. À l'état naturel, le cannabis contient entre 0,5 % et 5 % de concentration en THC. Les modes de culture sophistiqués, la sélection des plants, le choix entre des plants femelles, permettent d'atteindre des concentrations plus élevées, pouvant dans certains cas aller jusqu'à 30 %.

Tolérance
État induit par la consommation chronique d'une substance menant à une diminution de la réponse de l'organisme et une capacité plus grande de supporter ses effets.

Toxicité
Qualité spécifique à une substance d'entraîner l'intoxication. Le cannabis a une toxicité très faible et ne présente à peu près aucun risque de surdose.

Toxicomanie
Terme le plus fréquemment utilisé en langue française pour désigner les phénomènes que l'anglais désigne sous le terme *addiction*. Usage répété d'une ou plusieurs substances de telle sorte que l'usager (alors désigné sous le terme «toxicomane ») est en état régulier ou chronique d'intoxication, ressent le besoin de consommer, a de la difficulté à cesser la prise, et cherche à se procurer la substance. Cet état est généralement caractérisé par la tolérance et la dépendance à la substance ainsi que par un usage compulsif. Malgré son usage répandu, l'OMS a recommandé dès 1960 d'en abandonner l'usage pour cause d'imprécision, et de lui préférer le terme de dépendance.

PARTIE IV

OPTIONS DE POLITIQUE PUBLIQUE

CHAPITRE 19

LE CONTEXTE JURIDIQUE INTERNATIONAL

Ce chapitre pourrait commencer et se terminer sur une phrase : l'architecture des conventions internationales sur les drogues est un carcan qui, en ce qui concerne du moins le cannabis, est tout à fait irrationnel et n'a rien à voir avec des considérations scientifiques ni de santé publique.

Un carcan fort utile par ailleurs pour poursuivre une politique de prohibition, car lorsqu'à bout d'arguments scientifiques et de santé publique, les tenants de l'approche prohibitionniste ont beau jeu de s'en remettre aux conventions que le Canada a signées. Plus que signées en fait puisque grâce à certains hommes, policiers et fonctionnaires fédéraux, il en a été l'un des principaux protagonistes.

Il existe actuellement trois conventions qui régissent toutes les phases de la vie des drogues, depuis la culture des plantes jusqu'à la consommation personnelle. Ce sont la *Convention unique sur les stupéfiants de 1961* (Convention unique)[1], la *Convention sur les substances psychotropes* de 1971 (Convention sur les psychotropes)[2], et la *Convention contre le trafic illicite des stupéfiants et des substances psychotropes* de 1988[3] (Convention sur le trafic illicite). En plus de créer un droit international sur les drogues, elles créent aussi des organes et des modes de contrôle, soit politique soit bureaucratique.

Mais ces conventions ont une histoire qui a commencé bien avant la Convention unique. Histoire qui permet de mieux saisir les enjeux qui ont présidé à leur élaboration et de saisir le sens de ce qu'elles sont aujourd'hui ; c'est l'objet de la première section. Ces conventions créent des obligations, comme le suggère la deuxième section, des obligations détaillées mais qui n'en sont pas moins des obligations morales plutôt que des obligations en droit interne. Et ces conventions sont un patchwork de compromis laissant aux États une certaine marge de manœuvre que nous explorons à la troisième section.

---

[1] Convention unique sur les stupéfiants de 1961 (RTC 1964/30), modifiée par le Protocole portant amendement de la Convention unique sur les stupéfiants de 1961 (RTC 1976/48). La Convention unique est entrée en vigueur au Canada en 1964 et le Protocole en 1976.

[2] Convention sur les substances psychotropes, RTC 1988/35. Cette Convention est entrée en vigueur au Canada en 1988.

[3] Convention contre le trafic illicite des stupéfiants et des substances psychotropes, RTC 1990/42, entrée en vigueur au Canada en 1990.

ÉLÉMENTS DE GÉNÉALOGIE

L'architecture des conventions internationales qui régissent la production et le commerce des drogues est fascinante et unique. Tout commence au milieu du XIXe siècle alors que Royaume-Uni et la Chine se sont livrées deux guerres, rapidement gagnées par les Britanniques, au sujet du commerce de l'opium. Et dans cette partie de l'histoire, les rôles sont inversés : les Britanniques qui détiennent le monopole de l'opium de la Compagnie des Indes refusent d'abandonner ce commerce lucratif, alors que la Chine tente, depuis plusieurs décennies, de mettre fin à l'usage de l'opium, non pas tant pour des raisons sanitaires que pour des raisons économiques car ce trafic lui coûte cher.

> [Traduction] *« La Chine avait longtemps dominé les relations commerciales avec l'Occident, exportant soieries, poteries fines, thés et autres produits, tandis qu'elle attendait peu de l'extérieur. (...) L'exportation d'opium vers la Chine devenait ainsi, pour les gouvernements coloniaux, une manière de résoudre leur déficit commercial avec la Chine. La production d'opium était un gagne-pain pour de nombreux paysans, marchands, banquiers et fonctionnaires de l'état. Les exportations vers la Chine étaient une source de monnaie forte, réduisant ainsi les flux sorties de capitaux. »*[4]

Alors que Royaume-Uni regimbe à instaurer des mécanismes de contrôle qui la priveraient de cette rentrée de devises fortes, les États-Unis comprennent, au début du siècle, qu'il s'agit là d'une occasion rêvée pour s'imposer sur la scène internationale.

À ces éléments de géopolitique des drogues avant l'heure, se mélangent en un savant cocktail des attitudes racistes, des intérêts économiques et des intérêts de politique intérieure bien compris. Nous avons déjà fait mention, aux chapitres 10 et 12 de certains aspects du racisme antichinois qui ont marqué le début du siècle au Canada. La même chose se vérifiait aux États-Unis.

> *« Les États-Unis ont plusieurs raisons de donner suite à cette proposition. La raison officielle est d'ordre moral : à une époque où les ligues de tempérance et les églises réclament la Prohibition, l'Amérique puritaine décide de prendre la tête de la croisade mondiale de la civilisation. Elle prétend protéger les races non civilisées des méfaits de l'opium et des boissons alcooliques. Mais elle a également d'autres raisons moins avouables. Sous la pression des syndicats qui redoutent la concurrence de la main-d'œuvre d'origine chinoise, elle vote les Exclusion Laws, textes ouvertement xénophobes, destinés à contenir le péril jaune. Elle répand alors le mythe de « l'immonde opiomane chinois », adonné à son vice et prêt à contaminer la jeunesse américaine. »*[5]

Le gouvernement chinois a évidemment protesté fortement contre ces lois, mais l'Empire du Milieu, victime de ses conflits et de sa désorganisation interne, avait peu de moyens de s'imposer sur la scène internationale. Tout en continuant sa lutte contre la

---

[4] McAllister, W.B., (1999) *Drug Diplomacy in the Twentieth Century. An international history.* Pages 10-11.

[5] Caballero, F. et Y. Bisiou (2000) *Droit de la drogue.* Paris : Dalloz, 2e édition, page 36.

consommation d'opium sur son territoire, la Chine s'est donc mise elle-même à favoriser la production locale du pavot.

Par ailleurs, l'industrie pharmaceutique, qui était en pleine croissance depuis le milieu du XIXe siècle, pouvait produire de plus en plus de médicaments à faible prix, dont plusieurs contenaient des extraits de coca ou d'opium.

> [Traduction] *« Au milieu des années 1880, la réaction euphorique à la découverte de la cocaïne fit boule de neige. Les compagnies pharmaceutiques s'empressèrent de passer des commandes, mais comme la quantité de feuilles de coca fraîches était insuffisante, les prix ont explosé. Pour satisfaire à la demande et participer à la manne, certaines puissances impériales augmentèrent leurs efforts afin de développer le commerce de la coca. (...) En quelques années, la production augmenta significativement, la production de pâte de coca se répandait, tandis que les feuilles de coca étaient une marchandise négociée sur les places financières et que les compagnies pharmaceutiques se faisaient la lutte pour les meilleurs prix, la disponibilité et la qualité du produit. Encore peu disponible en 1885, la cocaïne devint bientôt l'emblème de l'économie politique internationale, moderne et technologique. (...) Au début du XXe siècle, la cocaïne était en troisième place en terme de valeur parmi toutes les drogues, la popularité encore plus grande de la morphine et de la quinine résultant de la même constellation de facteurs – un complexe pharmaceutico-industriel en pleine expansion. »* [6]

Troisième élément, la professionnalisation et le pouvoir social croissants du corps médical. Il s'agissait en quelque sorte de lutter contre une médecine populaire, réputée génératrice d'abus et de charlatanisme, mais surtout exercée en marge des corporations de médecins et donc moins contrôlée par «l'autorité» médicale savante. Sûr de sa science, le puissant lobby médical allait rapidement s'imposer pour demander une réglementation des drogues et le pouvoir unique de diagnostic et de prescription.

Enfin, quatrième élément et non le moindre, s'ajoutent les considérations morales. Les mouvements de tempérance luttant contre les «vices» moraux et sociaux que représentaient l'alcool et les drogues étaient en pleine expansion et portaient un pouvoir politique important que les prohibitionnistes ont su utiliser brillamment.

Le coup de pouce final viendra de la décision, en 1906, du nouveau gouvernement britannique libéral de s'opposer au commerce de l'opium imposé entre l'Inde et la Chine, si bien que le gouvernement chinois a pu amorcer une vaste campagne contre la consommation et la production de l'opium. La Grande-Bretagne a convenu, en 1907, de réduire de 10 % par année les exportations d'opium indien vers la Chine, tant que cette dernière permettrait une vérification indépendante des réductions apportées à sa propre production. L'accord s'est avéré plus efficace que ne l'avaient prévu les deux pays, jusqu'à la chute de la dynastie Manchu (Ch'ing) en 1911, après laquelle les seigneurs de guerre chinois ont commencé à encourager la production de l'opium sur une grande échelle en vue de financer leurs dépenses militaires. Néanmoins, les futurs tenants de la prohibition devaient considérer l'« accord de dix ans » de 1907 comme le premier « traité » de l'opium couronné de succès ; pendant les 60 prochaines années, cet

---

[6] McAllister, *op. cit.*, pages 15-16.

accord allait donner le ton aux négociations relatives au contrôle international des stupéfiants[7]. La table était mise pour la première d'une longue suite de conférences internationales et de traités et conventions qui en ressortiraient, comme le démontre le tableau suivant.[8]

Accords multilatéraux sur les stupéfiants et les substances psychotropes[9]

Date et lieu de la signature	*Titre de l'accord*	*Date d'entrée en vigueur*
26 février 1909 Shanghai, Chine	Résolutions finales de la Commission internationale de l'opium [1]	Sans objet
23 janvier 1912 La Haye, Pays Bas	Convention internationale de l'opium	11 février 1915 / 28 juin 1919 [2]
11 février 1925 Genève, Suisse	Accord concernant la fabrication, le commerce intérieur et l'usage de l'opium préparé	28 juillet 1926
19 février 1925 Genève, Suisse	Convention internationale de l'opium	25 septembre 1928
13 juillet 1931 Genève, Suisse	Convention pour limiter la fabrication et réglementer la distribution des stupéfiants [3]	9 juillet 1933
27 novembre 1931 Bangkok, Thaïlande	Accord sur le contrôle de la consommation d'opium dans l'Extrême-Orient	22 avril 1937
26 juin 1936 Genève, Suisse	Convention pour la répression du trafic illicite des drogues nuisibles	26 octobre 1939
11 décembre 1946 Lake Success, New York, É.-U.	Protocole portant amendement aux Accords, Conventions et Protocoles sur les stupéfiants, conclus à La Haye le 23 janvier 1912, à Genève le 11 février 1925, le 19 février 1925 et le 13 juillet 1931, à Bangkok le 27 novembre 1931, et à Genève le 26 juin 1936	11 décembre 1946
19 novembre 1948 Paris, France	Protocole plaçant sous contrôle international certaines drogues non visées par la Convention du 13 juillet 1931 pour limiter la fabrication et réglementer la distribution des stupéfiants, amendé par le Protocole signé à Lake Success, New York, le 11 décembre 1946	1er décembre 1949
23 juin 1953 New York, É.-U.	Protocole visant à limiter et à réglementer la culture du pavot, ainsi que la production, le commerce international, le commerce de gros et l'emploi de l'opium	8 mars 1963
30 mars 1961	Convention unique sur les stupéfiants de 1961	13 décembre 1964

[7] McAllister, *op. cit.*, pages 24-27.

[8] Ce tableau, ainsi que le texte de cette section sont le fruit de l'excellent rapport préparé à la demande du Comité par la Bibliothèque du Parlement : Sinha, J. (2001) *L'histoire et l'évolution des principales conventions internationales de contrôle des stupéfiants*. Ottawa : Bibliothèque du Parlement, Direction de la recherche parlementaire, disponible sur le site Internet du Comité à www.parl.gc.ca/drogues-illicites.asp

[9] Sources : Recueil des traités du Canada; Kettil Bruun, Lynn Pan et Ingemar Rexed, (1975) *The Gentlemen's Club: International Control of Drugs and Alcohol*, Chicago : University of Chicago Press; États-Unis, (1972) *International Narcotics Control: A Source Book of Conventions, Protocols, and Multilateral Agreements, 1909-1971*, Washington (D.C.), Bureau of Narcotics & Dangerous Drugs.

New York, É.-U.		
21 février 1971 Vienne, Autriche	Convention sur les substances psychotropes	16 août 1976
25 mars 1972 Genève, Suisse	Protocole portant amendement à la Convention unique sur les stupéfiants de 1961	8 août 1975
20 décembre 1988 Vienne, Autriche	Convention des Nations Unies contre le trafic illicite de stupéfiants et de substances psychotropes	11 novembre 1990

[1] Il s'agit de l'unique document du Tableau qui n'est pas un traité multilatéral exécutoire. Nous l'avons inclus parce qu'il marque le début d'une importante collaboration internationale en matière de contrôle de stupéfiants.
[2] La Chine, les Pays Bas et les États-Unis ont mis en application la Convention en 1915 (le Honduras et la Norvège ont emboîté le pas la même année). C'est uniquement à l'intégration de la Convention dans le Traité de Versailles en 1919 qu'elle est entrée en vigueur à l'échelle mondiale.
[3] Modifiée par le Protocole signé à Lake Success, New York, le 11 décembre 1946.

La Conférence de Shanghai (1909)

L'intérêt des États-Unis à l'égard du contrôle international des stupéfiants s'est considérablement accru à la suite de la Guerre hispano-américaine, qui a mené à l'acquisition des Philippines par l'Amérique en 1898.[10] Avec cette acquisition, l'administration américaine héritait en effet d'une situation qui, à ses yeux, constituait un problème sérieux : un monopole étatique de l'approvisionnement en opium. Sous la direction du nouvel évêque épiscopal des Philippines, Charles Henry Brent, le monopole a été aboli, mais la contrebande continuait ; Brent, qui percevait le problème de l'opium comme une question morale et l'usage de stupéfiants comme un « *vice social… un crime* » a convaincu le président Theodore Roosevelt d'appuyer l'organisation d'une réunion internationale à Shanghai afin de corriger ce qui était manifestement un problème régional.[11]

En février 1909, la Commission internationale de l'opium[12] s'est réunie à Shanghai, et Brent en était le président. Toutefois, parce que les participants ne disposaient pas des pouvoirs plénipotentiaires requis pour conclure un traité, le résultat de la réunion a été simplement une compilation de faits et un ensemble de recommandations non contraignantes. Durant les discussions au sujet du mandat de la Commission, on s'est demandé si cette dernière devait tenir compte de questions de nature médicale associées aux drogues, telles que la toxicomanie et son traitement ; la proposition a été rejetée (par une majorité d'une voix) parce qu'on croyait que la représentation de l'expertise médicale était inadéquate à la réunion.[13] Il s'agissait d'un

[10] Lowes, P.D., (1966) *The Genesis of International narcotics Control.* Genève : Droz, page 102.
[11] Bewley-Taylor, D.R., (1999) *The United States and International Drug Control.*, page 19.
[12] La Commission réunissait toutes les puissances coloniales de la région – la Grande-Bretagne, la France, l'Allemagne, le Japon, les Pays-Bas, le Portugal et la Russie – ainsi que la Chine, le Siam [aujourd'hui la Thaïlande], la Perse [aujourd'hui l'Iran], l'Italie et l'Autriche-Hongrie (McAllister (2000)) *op. cit.*, page 28).
[13] Bruun *et coll.*. (1975), *op. cit.*. page 11; Lowes (1966), *op. cit.*. page 187-188.

précédent lourd de conséquences : à la plupart des réunions futures, il y aurait surtout des diplomates et des fonctionnaires, et une contribution peu importante des experts en médecine.

Les négociations menées durant les réunions de la Commission ont préparé le terrain pour les conférences subséquentes. Les États-Unis, représentés de manière agressive par Hamilton Wright, ont tenté de convaincre les puissances coloniales d'appuyer une définition étroite de l'« usage légitime » de l'opium, selon laquelle tout usage non médical ou non scientifique – à la lumière des normes médicales et scientifiques occidentales – serait jugé illicite. Les puissances coloniales ont défendu une approche moins rigoureuse, qui permettrait un « usage quasi-médical ». Dans la formulation finale de la Résolution 3, la Commission concluait que [Traduction] « *l'usage de l'opium à toute fin autre que des fins médicales est* considéré *par* presque *tous les pays participants comme étant sujet à la prohibition* ou à une réglementation prudente ; *et chaque pays, dans le cadre de l'administration de son système ou de sa réglementation, vise dans la mesure du possible une rigueur de plus en plus grande* » [soulignés dans le texte original].

La Commission était, dans les faits, très peu « internationale ». On a ciblé principalement les problèmes liés à l'opium en Chine – cinq des neuf résolutions désignaient la Chine explicitement – et les États-Unis et la Grande-Bretagne ont dominé les discussions. Les États-Unis voulaient imposer la prohibition et estimaient que la Chine avait besoin d'aide pour venir à bout des problèmes liés à l'opium à l'intérieur de ses frontières. La Grande-Bretagne tentait de protéger son lucratif commerce d'opium indien, avançant que l'interruption de ce commerce serait inutile tant que la Chine ne maîtriserait pas sa production nationale.[14]

Il convient de signaler les objectifs politiques et économiques nationaux qui sous-tendaient la position rigoureuse de la délégation américaine à la réunion de Shanghai et qui devaient avoir une incidence sur les négociations ultérieures. On présumait que si les autres pays réglementaient leur production et leurs exportations d'opium, les États-Unis n'auraient pas à assumer cette tâche, puisque le pavot et la feuille de coca n'avaient jamais poussé en quantités importantes en Amérique du Nord. De plus, les accords internationaux poussant les pays à adopter des mesures internes drastiques renforçaient la position de Brent et de Wright, qui pressaient le gouvernement américain d'élaborer des lois rigoureuses en matière de contrôle des stupéfiants.[15]

---

[14] Walker III, W. O., (1991) *Opium and Foreign Policy: The Anglo-American Search for Order in Asia, 1912-1954*, Chapel Hill (C. du N.) : University of North Carolina Press, pages 16-17; Lowes (1966), *op. cit.*, pages 152-153.

[15] Musto, D.F., (1999) *The American Disease: Origins of Narcotic Control.* 3e édition, Oxford : Oxford University Press, pages 36-37.

La Convention internationale de l'opium de 1912 (La Haye)

À la réunion de Shanghai, les Américains avaient proposé la tenue d'une conférence pour élaborer un traité de contrôle international des stupéfiants qui inclurait les résolutions de Shanghai, mais dans une formulation élargie et plus rigoureuse. D'autres pays ont contesté cette proposition, si bien qu'elle est restée lettre morte. Cependant, au cours des années suivantes, les États-Unis ont fait campagne continuellement et vigoureusement partout dans le monde en vue d'une nouvelle conférence. S'attaquer au problème de l'opium directement, publiquement et à l'échelle internationale était pour les États-Unis un moyen de réaliser leurs objectifs nationaux en matière de contrôle des stupéfiants, soit mettre un terme au lucratif commerce de stupéfiants dominé par les puissances coloniales et, gagnant la faveur des Chinois, améliorer ainsi les relations économiques sino-américaines.[16]

Douze pays ont accepté de se réunir à La Haye, le 1er décembre 1911, afin d'élaborer un traité.[17] Encore une fois, Brent présidait la réunion et Wright dirigeait la délégation américaine. La plupart des pays avaient exigé des modifications au programme proposé par les États-Unis, qui visait principalement un contrôle rigoureux de la production, de la fabrication et de la distribution de l'opium en Asie. Par exemple, la Grande-Bretagne insistait pour que les drogues de synthèse – telles que la morphine, l'héroïne et la cocaïne – soient incluses dans les débats. Il s'agissait d'une tentative de diluer le programme axé sur l'opium et de détourner l'attention de la production d'opium indien. La Grande-Bretagne espérait aussi qu'un traité équitable entraînerait des règles de jeu uniformes permettant aux sociétés pharmaceutiques britanniques de rivaliser avec l'industrie allemande, qui dominait alors le secteur des drogues de synthèse.[18]

Les chapitres I et II de la *Convention internationale de l'opium* de 1912[19] (Convention de La Haye de 1912) visaient l'opium brut et traité. Par exemple, l'article 1 exigeait que les parties [Traduction] « *adoptent des lois et règlements efficaces visant à contrôler la production et la distribution de l'opium brut* », à moins que de telles lois ne soient déjà en vigueur. La Convention reconnaissait aussi le principe (proposé par la délégation américaine) que l'usage de l'opium soit restreint aux fins médicales et scientifiques. Le chapitre IV visait à réduire le trafic de stupéfiants en Chine.

La chapitre III portait sur le contrôle de l'autorisation, de la fabrication et de la distribution des drogues de synthèse, mais l'Allemagne a veillé à ce que les dispositions soient faibles et vagues. L'article 10 permettait aux pays de déployer leurs « meilleurs efforts » en vue de mettre en oeuvre ces contrôles. De plus, l'Allemagne a refusé de

---

16 McAllister, W.B., (1992) «Conflicts of Interest in the International Drug Control System », dans Walker III, W.O., (ed.) *Drug Control Policy: Essays in Historical and Comparative Perspective*, University Park (Pennsylvanie) : Pennsylvania State University Press, page 145.

17 Ces pays étaient l'Allemagne, la Chine, les États-Unis, la France, la Grande-Bretagne, les Pays-Bas, l'Italie, le Japon, la Perse [aujourd'hui l'Iran], le Portugal, la Russie et le Siam [aujourd'hui la Thaïlande].

18 McAllister (2000), *op. cit.*, pages 32-33; Bruun *et coll.*, (1975), *op. cit.*, pages 11-12.

19 Conclue le 23 janvier 1912, entrée en vigueur le 28 juin 1919.

signer le traité avant qu'on ne convienne que tous les pays devaient ratifier[20] la Convention pour qu'elle entre en vigueur. Il s'agissait d'une tactique efficace pour retarder les mesures de contrôle, puisqu'il a fallu près d'une décennie avant que tous les pays aient ratifié le traité – l'Allemagne elle-même a procédé à la ratification uniquement parce qu'il s'agissait d'une des conditions du Traité de Versailles de 1919 mettant un terme à la Première Guerre mondiale.[21]

Wright s'est servi de la Convention de La Haye de 1912 dans sa campagne en faveur d'une loi antidrogue américaine : selon lui, il fallait une loi fédérale pour que les États-Unis s'acquittent de leurs obligations dans le cadre de la Convention. En 1916, la Cour suprême des États-Unis a tranché dans le sens contraire, mais entre-temps la *Harrison Narcotics Act of 1914* était devenue la première loi fédérale sur le contrôle des stupéfiants aux Etats-Unis ; elle allait demeurer un pilier de la politique américaine en matière de lutte antidrogue pour les décennies à venir.[22]

La création de la Société des Nations (SDN) en 1919, à la suite de la Première Guerre mondiale, dotait la collectivité internationale d'un organisme central pour l'administration du contrôle des stupéfiants. En 1920, la SDN a mis sur pied le Comité consultatif sur le trafic de l'opium et d'autres drogues nuisibles – connu sous le nom du Comité consultatif de l'opium (CCO), le précurseur de la Commission des stupéfiants des Nations Unies. L'Organisation d'hygiène de la Société des Nations – précurseur de l'Organisation mondiale de la santé des Nations Unies – a également été créée. L'administration de la Convention de La Haye de 1912 relevait initialement des Pays-Bas, mais a été transférée à la Commission de contrôle de l'opium par le CCO. La mise en application de la Convention était peu étendue, car les pays siégeant à la Commission de contrôle de l'opium étaient ceux qui profitaient le plus du commerce des stupéfiants.[23]

La SDN s'est mise à examiner les questions sociomédicales (les enjeux liés à la « demande »), telles que les raisons qui poussent les gens à consommer de la drogue, les comportements qui constituent un usage abusif et les facteurs sociaux qui ont une incidence sur l'usage abusif. Cependant, la prohibition et les enjeux liés à l'« offre » ont rapidement repris la préséance, avec les préparatifs et les pourparlers – encore une fois lancés par les États-Unis – en vue d'un nouveau traité au milieu des années 1920. De manière générale, le régime international tendait à séparer l'étude des problèmes

---

[20] La ratification est le processus par lequel chaque pays promulgue une loi nationale de mise en oeuvre – à moins que des lois internes répondent déjà aux nouvelles obligations internationales – et, ainsi, consent à l'application du traité à l'intérieur de son territoire.

[21] McAllister (2000), *op. cit.*, pages 36-37; Bruun *et coll.*, (1975), *op. cit.*, page 12; Lowes (1966), *op. cit.*, pages 182-186

[22] Musto (1999), *op. cit.*, pages 59-63. Étant donné que la constitution américaine ne permettait pas un rôle fédéral direct dans la criminalisation de l'usage de drogues, Wright a élaboré la *Harrison Act* sous la forme d'un règlement fiscal – les médecins, pharmaciens, grossistes et détaillants devaient obtenir un timbre-taxe pour distribuer des drogues – et la mise en application de ce règlement relevait du ministère du Trésor. Ainsi, on a limité l'usage en restreignant l'accès. (McAllister (2000), *op. cit.*, page 35).

[23] McAllister (1992), *op. cit.*, pages 145-146.

médicaux et sociaux associés aux drogues – y compris les questions étiologiques – des problèmes associés au contrôle antidrogue.[24]

Les Conventions de l'opium de Genève (1925)

Même si les États-Unis avaient choisi de ne pas se joindre à la SDN, l'influence américaine sur les questions relatives au contrôle international des stupéfiants ne s'est pas estompée. Inquiets de l'effet limité de la Convention de La Haye de 1912 sur la contrebande de l'opium et, de plus en plus, sur celle des drogues fabriquées dans l'Asie de l'Est, les États-Unis ont pressé la SDN de convoquer une nouvelle conférence. La SDN craignait que si elle n'obtempérait pas, les États-Unis pourraient intervenir indépendamment.[25]

Entre novembre 1924 et février 1925, deux conférences ont été tenues successivement et deux traités distincts ont été conclus. La première Convention de Genève[26] visait les nations productrices d'opium ; les signataires pouvaient vendre de l'opium uniquement par l'entremise de monopoles gouvernementaux et étaient tenus de mettre fin au commerce entièrement dans un délai de 15 ans.

La deuxième Convention de Genève, la *Convention internationale de l'opium*[27] (Convention de Genève de 1925), avait pour but d'assujettir à des contrôles mondiaux une gamme élargie de drogues, **y compris, pour la première fois, le cannabis** – désigné sous le nom de « Indian hemp » (marijuana) à l'article 11 de la Convention. Les articles 21 à 23 exigeaient que les parties soumettent des données statistiques annuelles sur : les stocks et la consommation de drogues, la production d'opium et de coca brut, ainsi que la fabrication et la distribution d'héroïne, de morphine et de cocaïne. Le chapitre VI substituait à la Commission de contrôle de l'opium un Comité central permanent de l'opium (CCPO)[28] comportant huit membres. Le chapitre V de la seconde Convention établissait un régime de certification des importations, supervisé par le CCPO, afin de contrôler le commerce international de la drogue en limitant les quantités que chaque pays pouvait importer légalement.

Alors que la Convention de La Haye de 1912 avait mis l'accent sur les contrôles nationaux, les Conventions de Genève tentaient d'améliorer le contrôle transnational. Les États-Unis avaient proposé une adhésion stricte au principe de l'usage exclusivement médical et scientifique de la drogue, ainsi que des contrôles rigoureux sur

[24] McAllister (2000), *op. cit.*, pages 46-50; Lowes (1966), *op. cit.*, page 188.

[25] McAllister (2000), *op. cit.*, pages 50-51.

[26] *Accord concernant la fabrication, le commerce intérieur et l'usage de l'opium préparé*, conclu le 11 février 1925, entré en vigueur le 28 juillet 1926.

[27] Conclue le 19 février 1925, entrée en vigueur le 25 septembre 1928.

[28] Le CCPO devait être impartial et dépourvu de parti pris politique, mais son fonctionnement demeure extrêmement politique encore aujourd'hui (il existe toujours). Depuis sa création, il a toujours compté un représentant de la Grande-Bretagne, des États-Unis et de la France (McAllister (2000), *op. cit.*, page 83).

la production des drogues à la source. Lorsque ces propositions ont essuyé un rejet catégorique à la seconde conférence, la délégation américaine a quitté la conférence et n'a jamais signé les traités. De plus, la délégation chinoise s'est retirée parce qu'aucun accord sur la suppression de la consommation de l'opium n'a pu être conclu.[29] Les deux pays se sont plutôt concentrés sur la mise en application de la Convention de La Haye de 1912.

La Convention de Genève pour limiter la fabrication et réglementer la distribution des stupéfiants (1931) / Accord de Bangkok sur la consommation d'opium (1931)

Le système de contrôle des importations mis en place à la suite de la Convention de Genève de 1925 ne s'est avéré efficace qu'en partie, car il suffisait d'acheminer les drogues par des pays non-signataires. En 1931, la Société des Nations a convoqué une nouvelle conférence à Genève afin d'imposer des limites à la fabrication de la cocaïne, de l'héroïne et de la morphine, et de contrôler leur distribution. Le résultat de cette conférence a été la *Convention pour limiter la fabrication et réglementer la distribution des stupéfiants*[30] (La Convention de limitation de 1931).

À compter de 1931, le Canada – qui s'était contenté de réagir aux efforts en matière de contrôle international des stupéfiants – a commencé à jouer un rôle actif en appuyant les efforts américains visant à élargir le contrôle à la source. Le colonel Charles Henry Ludovic Sharman, chef de la Division des stupéfiants – au sein du ministère des Pensions et de la Santé nationale – est devenu le maître d'oeuvre de la politique nationale et internationale du Canada en matière de drogues jusqu'aux années 1960. Le Canada, par l'entremise de Sharman, a grandement contribué aux négociations menant à la Convention de limitation de 1931.[31]

Il y avait aussi un nouvel acteur au sein de la délégation américaine : Harry J. Anslinger, premier Commissaire du nouveau *Federal Bureau of Narcotics* – il occuperait ce poste pendant 33 ans. Entièrement dévoué à la prohibition et au contrôle des stupéfiants à la source, Anslinger figure, de l'avis de nombreux observateurs, parmi ceux qui ont le plus grandement influencé l'élaboration de la politique américaine en matière de lutte antidrogues et, par conséquent, le contrôle international des stupéfiants jusqu'au début des années 1970.[32]

L'élément central de la Convention de limitation de 1931 était le régime de limitation de la fabrication exposé dans les chapitres II et III. Les parties étaient tenues

[29] Bruun *et coll.*, (1975), *op. cit.*, page 14.

[30] Conclue le 13 juillet 1931, entrée en vigueur le 9 juillet 1933.

[31] Giffen *et coll.*, (2000), *Panic and Indifference. The Politics of Canada's Drug Laws.* Ottawa : Centre canadien du lutte contre l'alcoolisme et les toxicomanies, page 483.

[32] Voir, par exemple, McAllister (2000), *op. cit.*, pages 89-90; Bewley-Taylor (1999), *op. cit.*, pages 102-164; Bruun *et coll.*, (1975) *op. cit.*, pages 137-141; Inglis, B. (1975) *The Forbidden Game: A Social History of Drugs.* Londres : Hodder & Stoughton, pages 181-190. Voir aussi Harry J. Anslinger et Will Oursler, « The War against the Murderers », dans Walker III, W.O. (1996) (ed.)., *Drugs in the Western Hemisphere: An Odyssey of Cultures in Conflict*, Wilmington (Delaware), Scholarly Resources Inc., 1996.

de soumettre au CCPO des estimations de leurs besoins nationaux en matière de drogues à des fins médicales et scientifiques ; à la lumière de ces estimations, le CCPO devait calculer les plafonds de fabrication pour chacun des pays signataires. Un Organe de contrôle des stupéfiants (OCS) a été mis sur pied pour administrer le régime. L'article 26 réduisait considérablement l'efficacité de la Convention: les États n'assumaient aucune responsabilité découlant de la Convention en ce qui a trait à leurs colonies. L'article 15 obligeait les États à mettre sur pied une « administration spéciale » de contrôle national des stupéfiants, modelée dans une certaine mesure sur l'appareil de contrôle national américain.[33]

La Convention est entrée en vigueur rapidement parce que plusieurs pays et la SDN croyaient qu'elle pourrait servir de modèle aux négociations sur le contrôle des armements. La SDN a même préparé un rapport visant à expliquer comment les principes établis dans la Convention de Genève de 1925 et la Convention de limitation pouvaient s'appliquer aux questions de désarmement.[34]

À la fin de 1931, une nouvelle conférence a été organisée au sujet de la consommation d'opium en Extrême-Orient. Le traité[35] conclu était faible, principalement parce que les États-Unis ont assisté à la conférence à titre d'observateur et que les puissances coloniales européennes n'étaient pas disposées à mettre en place des moyens efficaces pour contrôler l'usage de l'opium pendant une période où la surproduction et la contrebande étaient importantes. Le fait que la stratégie américaine axée sur la prohibition totale avait peu d'effet sur la contrebande et la consommation d'opium dans les Philippines ne facilitait pas la tâche des États-Unis, qui proposaient l'élimination de la culture du pavot. La principale conséquence de la conférence de Bangkok a été de convaincre les États-Unis de la nécessité d'une approche plus ferme pour lutter contre la production des matières premières et la contrebande de drogues illicites.[36]

La Convention pour la répression du trafic illicite des drogues nuisibles (Genève, 1936)

Prenant appui sur des initiatives menées par la Commission internationale de police criminelle – le précurseur de l'Organisation internationale de police criminelle (INTERPOL) – on a amorcé des négociations en 1930 en vue d'élaborer un traité pour

---

[33] Par la suite, Anslinger a régulièrement eu recours à cette disposition pour protéger sa position et éviter que le Federal Bureau of Narcotics soit modifié au moyen d'une réorganisation (McAllister (2000), *op. cit.*, pages 98 et 108-109).

[34] *Ibid.*, pages 110-111.

[35] Accord sur le contrôle de la consommation d'opium dans l'Extrême-Orient, conclu le 27 novembre 1931, entré en vigueur le 22 avril 1937.

[36] Taylor, A.C., (1969) *American Diplomacy and the Narcotics Traffic, 1900-1939: A Study in International Humanitarian Reform* Durham (N.C.) : Duke University Press, pages 275-279; McAllister (2000), *op. cit.*, page 106.

contrer le trafic illicite de drogues et punir sévèrement les trafiquants au moyen de sanctions criminelles.[37]

En 1936, on a conclu la *Convention pour la répression du trafic illicite des drogues nuisibles*[38] (Convention pour la répression du trafic de 1936) à Genève. Les États-Unis, menés par Anslinger, avaient tenté d'inclure dans le traité la criminalisation de toutes les activités – la culture, la production, la fabrication et la distribution – liées à l'usage de l'opium, du coca (et de ses dérivés) et du cannabis à des fins autres que médicales et scientifiques. De nombreux pays se sont opposés à cette proposition et le trafic illicite est demeuré au cœur des débats.[39] L'article 2 de la Convention encourageait les pays signataires à utiliser leur système national de droit criminel afin de réprimer [Traduction] « *sévèrement* », « *en particulier au moyen de l'incarcération ou d'autres sanctions de privation de la liberté* », les actes directement liés au trafic de stupéfiants.

Les États-Unis ont refusé de signer la version finale de la Convention, qu'ils jugeaient trop faible, particulièrement en ce qui a trait à l'extradition, à l'extraterritorialité et à la confiscation des recettes du trafic. Les Américains craignaient aussi que, en signant le traité, ils aient à assouplir leur régime national de contrôle criminel afin de se conformer à la Convention. En fait, la Convention n'a jamais bénéficié d'une acceptation générale, puisque la plupart des pays intéressés à cibler les trafiquants ont conclu leurs propres traités bilatéraux.

Malgré la faiblesse de son impact général, la Convention pour la répression du trafic de 1936 marquait un point tournant : tous les traités antérieurs avaient porté sur la réglementation d'activités « licites » liées aux drogues, tandis que la Convention pour la répression du trafic de 1936 faisait de ces activités un crime international passible de sanctions pénales.

La Deuxième Guerre mondiale

À la fin des années 1930, le Comité consultatif de l'Opium (CCO) de la SDN a commencé à remettre en question le fait que le régime de contrôle international des stupéfiants soit axé sur la prohibition et la répression criminelle. Certains pays proposaient de contrer la toxicomanie au moyen d'approches liées à la santé publique, notamment le traitement psychologique, les centres de santé et les programmes de sensibilisation. Faisant valoir l'opinion américaine que seule l'institutionnalisation permettait de guérir les toxicomanes, Anslinger, appuyé par Sharman, a réussi à bloquer tous les efforts du CCO visant à envisager des approches sociales et étiologiques aux problèmes causés par la drogue. Sur l'insistance d'Anslinger, on a plutôt continué de mettre l'accent sur l'élaboration d'un nouveau traité pour imposer la prohibition et le contrôle de l'approvisionnement à l'échelle mondiale.[40]

---

[37] Taylor (1969) *op. cit.*, pages 288-298
[38] Conclue le 26 juin 1936, entrée en vigueur le 26 octobre 1939
[39] Taylor (1969) *op. cit.*, pages 293-295.
[40] McAllister (2000), *op. cit.*, pages 126-127.

Ironiquement, en prévision de la guerre, de nombreux pays (en particulier les États-Unis) ont amassé des réserves d'opium et de produits de l'opium destinés à un usage médical.[41] La Deuxième Guerre mondiale a mis en veilleuse le développement plus poussé de l'appareil de contrôle international des stupéfiants.

Le Protocole de Lake Success (1946)

Après la guerre, on a intégré les organismes et fonctions de contrôle des stupéfiants de la SDN au sein de la nouvelle Organisation des Nations Unies.[42] Le Conseil économique et social des Nations Unies a assumé la principale responsabilité, par l'entremise de sa Commission des stupéfiants, qui remplaçait le CCO. Sous la direction de la Commission des stupéfiants, la Division des stupéfiants était chargée des travaux préparatoires aux conférences. Le CCPO et l'OCS ont poursuivi leurs activités sous la Commission des stupéfiants, assumant leurs rôles respectifs de compilation de statistiques pour les estimations nationales et d'administration des traités antérieurs. Le Canadien Sharman est devenu le premier président de la Commission des stupéfiants et il a siégé à l'OCS.

Tous ces changements sur le plan des responsabilités et de l'organisation nécessitaient des amendements aux traités de contrôle international des stupéfiants. On a convenu de ces amendements dans un Protocole[43] signé à Lake Success, New York, le 11 décembre 1946.

Le Protocole de Paris (1948)

Anslinger et Sharman ont déployé de nombreux efforts pour faire en sorte que la Commission des stupéfiants relève directement du Conseil économique et social, à titre d'organisation indépendante. Ils craignaient que, si le principal appareil de contrôle des stupéfiants était une plus vaste organisation chargée de la santé ou des enjeux sociaux – telle que l'Organisation mondiale de la santé (OMS) ou l'Organisation des Nations Unies pour l'éducation, la science et la culture (UNESCO) – les questions liées à l'étiologie et au traitement puissent l'emporter sur la prohibition. En particulier, ils voulaient s'assurer que les gouvernements seraient représentés par des agents

---

[41] La possibilité d'une guerre a accentué l'hypocrisie et le caractère opportuniste de la position américaine en matière de prohibition. En 1939, Anslinger [Traduction] « *tentait simultanément de réaliser un traité sous l'égide de la Société des Nations visant à réduire la production agricole dans les pays lointains, un accord régional qui lui permettrait de commencer la culture du pavot aux États-Unis, ainsi qu'un programme mondial d'acquisition qui a amassé la plus grande réserve d'opium licite jamais rassemblée* » (McAllister (2000), *op. cit.*, page 133).

[42] Voir Bewley-Taylor (1999), *op. cit.*, pages 54-59; Bruun *et al.* (1975) *op. cit.*, pages 54-65

[43] Protocole portant amendement aux Accords, Conventions et Protocoles sur les stupéfiants conclus à La Haye le 23 janvier 1912, à Genève le 11 février 1925 et le 19 février 1925 et le 13 juillet 1931, à Bangkok le 27 novembre 1931, et à Genève le 26 juin 1936, conclu le 11 décembre 1946, entré en vigueur le 1er décembre 1946.

responsables de l'application des lois, plutôt que par des médecins ou d'autres intervenants des domaines de la sociologie ou de la santé publique. De plus, l'URSS disait vouloir considérer les facteurs sociaux qui sous-tendent l'abus des drogues. Pour les puissances occidentales, être d'accord avec l'Union soviétique aurait miné leur position inébranlable à l'égard de Moscou et du communisme dans le cadre de la Guerre froide qui se dessinait.

Bien que le Conseil économique et social ait conservé la responsabilité principale, l'Organisation mondiale de la santé (OMS) – et en particulier son comité d'experts des drogues engendrant la toxicomanie – a été chargée de déterminer quelles substances devaient être soumises à la réglementation.[44] Ce pouvoir a été attribué à l'OMS dans un Protocole international[45] signé à Paris en 1948. L'article premier prévoyait que si l'OMS constatait qu'une drogue [Traduction] « *est apte à engendrer la toxicomanie ou peut être convertie en un produit apte à engendrer la toxicomanie* », l'OMS déterminerait sa classification au sein de la structure de contrôle international des stupéfiants. Le Protocole plaçait également sous contrôle international certains opiacés synthétiques qui n'étaient pas visés par les traités antérieurs.

Le Protocole de l'opium de New York (1953)

À la fin des années 1940, il était clair que le nombre élevé de traités, comportant différents types et niveaux de contrôle, était une source de confusion et de complexité. Anslinger, Sharman et leurs alliés ont veillé à ce que la Commission des stupéfiants recommande au Conseil économique et social de réunir tous les traités existants en un seul document – ce qui serait également l'occasion de mettre en place des contrôles prohibitionnistes plus rigoureux.[46] Il a fallu mettre ce plan en veilleuse pendant une décennie lorsque le directeur de la Division des stupéfiants, Leon Steinig, a proposé la création d'un « monopole international de l'opium » en vue de mettre fin au trafic illicite et de garantir un approvisionnement de gros en opium licite.

Au long des années 1950, les tensions de la Guerre froide ont poussé Anslinger à reconstituer la réserve américaine d'opium et de dérivés de l'opium, souvent en effectuant des achats importants auprès de l'Iran par l'entremise d'entreprises pharmaceutiques américaines. De nombreux pays européens se constituaient aussi une réserve. Les entreprises pharmaceutiques multinationales dans ces pays et aux États-Unis craignaient qu'un monopole similaire à celui que proposait Steinig entraîne des

---

[44] Bruun *et al.* (1975), *op. cit.*, page 70.

[45] Protocole plaçant sous contrôle international certaines drogues non visées par la Convention du 13 juillet 1931 pour limiter la fabrication et réglementer la distribution des stupéfiants, amendé par le Protocole signé à Lake Success, le 11 décembre 1946, conclu le 19 novembre 1948, entré en vigueur le 1er décembre 1949

[46] Le Conseil économique et social (ECOSOC) a approuvé la recommandation au moyen de deux résolutions : 159 II D (VII) du 3 août 1948, et 246 D (IX) du 6 juillet 1949. Voir aussi McAllister (2000), *op. cit.*, page 172; Bewley-Taylor (1999) *op. cit.*, page 137.

restrictions et une hausse des prix. Anslinger et Sharman ainsi que les Britanniques, les Hollandais et les Français, ont mis fin aux discussions sur le monopole au sein de la Commission des stupéfiants. Le représentant français auprès de la Commission des stupéfiants, Charles Vaille, a suggéré un nouveau protocole de l'opium à titre de solution provisoire, en attendant le regroupement des traités. Le Conseil économique et social a approuvé une conférence de plénipotentiaires et Anslinger s'est servi de l'établissement de ce nouveau protocole pour imposer des contrôles mondiaux sévères de la production d'opium.[47]

On a mis la dernière main au Protocole[48] (Protocole de l'opium de 1953) à New York en 1953. L'article 2 disposait carrément que les parties étaient tenues de « restreindre l'emploi de l'opium exclusivement aux besoins médicaux et scientifiques ». Le Protocole comportait diverses dispositions visant la culture du pavot, de même que la production et la distribution de l'opium. L'article 6 limitait la production de l'opium à sept pays, et les parties pouvaient importer ou exporter seulement l'opium produit dans un de ces pays.[49] Le Protocole de l'opium de 1953 comportait les dispositions de contrôle international les plus rigoureuses de l'histoire, mais n'a jamais obtenu le soutien qu'Anslinger avait souhaité. Ce n'est qu'en 1963 qu'il a atteint le nombre de ratifications requis pour sa mise en œuvre ; toutefois, à cette date, la Convention unique de 1961 avait déjà remplacé le Protocole.

LES TROIS CONVENTIONS ACTUELLES

La Convention unique sur les stupéfiants de 1961

La Convention unique a joué un rôle central dans la création du système moderne de contrôle international des stupéfiants axé sur la prohibition. Il s'agit d'un prolongement et d'un élargissement de l'infrastructure juridique élaboré entre 1909 et 1953.

Le regroupement des traités sur le contrôle international des stupéfiants en un seul instrument s'est amorcé en 1948, mais ce n'est qu'en 1961 qu'on a disposé d'une troisième version préliminaire acceptable qu'on pouvait présenter à une conférence de plénipotentiaires.[50] La conférence a débuté le 24 janvier 1961 à New York et 73 pays y

---

[47] McAllister (2000) *op. cit.*, pages 172-179.

[48] Protocole visant à limiter et à réglementer la culture du pavot, ainsi que la production, le commerce international, le commerce de gros et l'emploi de l'opium, conclu le 23 juin 1953, entré en vigueur le 8 mars 1963.

[49] Les sept pays producteurs étaient : la Bulgarie, la Grèce, l'Inde, l'Iran, la Turquie, l'URSS et la Yougoslavie.

[50] Délégué canadien auprès de la Commission des stupéfiants, Robert Curran, un agent du ministère de la Santé nationale et du Bien-être social, a joué le rôle le plus important dans la formulation d'un

étaient représentés, chacun ayant [Traduction] « *un programme fondé sur ses propres priorités nationales* ».[51]

William B. McAllister a réparti les États participants en cinq catégories distinctes, selon leur position et leurs objectifs en matière de contrôle des stupéfiants :

- Groupe des États producteurs de matière première : *À titre de producteurs de la matière première organique pour la plus grande partie de l'approvisionnement mondial en drogues, ces pays avaient été le point de mire traditionnel des efforts de contrôle international des stupéfiants. Ils étaient disposés à accepter un usage socioculturel de la drogue, puisqu'ils avaient connu un tel usage durant des siècles. Bien que l'Inde, la Turquie, le Pakistan et la Birmanie en aient été les chefs de file, le groupe comptait aussi les États producteurs de coca de l'Indonésie et de la région andine de l'Amérique du Sud, les pays producteurs d'opium et de cannabis de l'Asie du Sud et du Sud-Est, ainsi que les États producteurs de cannabis de la Corne de l'Afrique. Ils étaient en faveur de contrôles souples parce que les restrictions existantes à la production et à l'exportation avaient directement touché d'importantes sections de leur population et de leur industrie nationale. Ils appuyaient des efforts de contrôle nationaux tenant compte de leur situation nationale et se méfiaient des puissants organismes de contrôle international sous l'égide des Nations Unies. Bien qu'essentiellement impuissants à s'opposer à la philosophie prohibitionniste, ils ont, de fait, imposé un compromis en se concertant pour diluer la formulation du traité au moyen d'exceptions, d'échappatoires et de reports. Ils ont également demandé des aides au développement pour contrebalancer les pertes causées par les contrôles rigoureux.*

- Groupes des États fabricants : *Ce groupe comptait principalement des pays industrialisés occidentaux, dont les intervenants clés étaient les États-Unis, la Grande-Bretagne, le Canada, la Suisse, les Pays-Bas, l'Allemagne de l'Ouest et le Japon. Sans affinité culturelle à l'égard de la consommation des drogues d'origine végétale et confrontés aux effets de la toxicomanie chez leurs citoyens, ils préconisaient un contrôle très rigoureux de la production des matières premières brutes et du trafic illicite. En tant que principaux fabricants des psychotropes synthétiques (et appuyés par un lobby industriel déterminé), ils se sont fortement opposés aux restrictions injustifiées à la recherche médicale ou à la production et à la distribution des drogues de synthèse. Ces pays étaient en faveur de puissants organismes de contrôle supranational dans la mesure où ils conserveraient la direction* de facto *de ces organismes. Leur stratégie consistait essentiellement à* [Traduction] *« déplacer dans la mesure du possible le fardeau réglementaire vers les États producteurs des matières premières, tout en conservant la plus grande liberté possible dans leurs activités ».*

- Groupe du contrôle rigoureux : *Il s'agissait essentiellement des pays non-producteurs et non-fabricants qui n'avaient aucun intérêt économique dans le commerce de la drogue. Les principaux*

---

document qui serait acceptable pour tous les pays à titre de point de départ des négociations (McAllister (2000) *op. cit.*, page 205). Pour une analyse de cette troisième version préliminaire, voir Leland M. Goodrich, (1960) « New Trends in Narcotics Control », *International Conciliation*, nº 530, novembre.

[51] McAllister (1992) *op. cit.*, page 148.

intervenants étaient la France, la Suède, le Brésil et la Chine nationaliste. La plupart des États de ce groupe s'opposaient pour des raisons culturelles à l'usage de stupéfiants et souffraient de problèmes de toxicomanie. Ils étaient en faveur d'un usage exclusivement médical et scientifique, et étaient disposés à sacrifier une certaine mesure de leur souveraineté nationale pour garantir l'efficacité des organismes de contrôle supranational. Ils ont dû atténuer leurs exigences pour obtenir l'accord le plus général possible.

- Groupe du contrôle faible : *Ce groupe était mené par l'Union soviétique et comptait souvent ses alliés en Europe, en Asie et en Afrique. Ces pays considéraient le contrôle des stupéfiants comme une question purement interne et ils s'opposaient de manière véhémente à toute ingérence dans la souveraineté nationale, telle que les inspections indépendantes. Ayant peu d'intérêts dans le commerce de la drogue et souffrant peu de problèmes de toxicomanie, ils refusaient d'accorder à tout organisme supranational des pouvoirs excessifs, particulièrement des pouvoirs sur la prise de décisions interne.*

- Groupe neutre : *Ce groupe diversifié comptait la plupart des pays africains, l'Amérique centrale, l'Amérique du Sud subandine, le Luxembourg et le Vatican. La question ne comportait aucun intérêt important pour eux, sauf l'accès garanti à un approvisionnement suffisant en médicaments. Certains ont voté en se ralliant à des blocs politiques, d'autres étaient prêts à échanger leurs votes, et d'autres encore étaient véritablement neutres, si bien que leurs votes dépendaient de la force persuasive des arguments présentés. En général, ils appuyaient le compromis visant à obtenir l'accord maximal.*

Le résultat de tous ces intérêts rivaux a été un document qui symbolisait le compromis : la Convention unique maintenait et élargissait clairement les contrôles existants et, compte tenu de sa portée, constituait le document le plus prohibitionniste jamais adopté, même si elle était moins rigoureuse qu'elle aurait pu l'être. Elle omettait les aspects coûteux du Protocole de l'opium de 1953, tels que la disposition limitant la production de l'opium aux sept pays énumérés. Sharman ne négociait plus pour le Canada et Anslinger avait joué un rôle mineur à la conférence en raison de conflits avec le *State Department* des États-Unis. Ce dernier était satisfait de la Convention puisque l'influence américaine était garantie au sein des organismes de supervision des Nations Unies et que le cadre de prohibition avait été élargi de manière à inclure des contrôles serrés sur le coca et le cannabis. Étant donné que la Convention unique était une initiative lancée par les États-Unis, les Américains auraient perdu du respect au sein de l'ONU s'ils s'étaient retirés de la conférence et auraient en outre donné une impression de faiblesse devant l'Union soviétique durant une période tendue de la Guerre froide.[52]

---

[52] Anslinger était extrêmement déçu de la Convention unique parce qu'il croyait que les dispositions sur le contrôle de l'opium n'étaient pas suffisamment rigoureuses (p. ex. l'article 25 permettait encore à tout pays de produire jusqu'à cinq tonnes d'opium annuellement, bien que cette production soit assujettie à des mesures de contrôle strictes). Il a tenté de faire dérailler la Convention en pressant des pays de ratifier le Protocole de l'opium de 1953, espérant ainsi obtenir le nombre requis pour assurer

Les principaux fondements des traités antérieurs sont demeurés en place dans la Convention unique.[53] Les parties étaient encore tenues de soumettre des estimations de leurs besoins en drogues et de fournir des rapports statistiques sur la production, la fabrication, l'usage, la consommation, l'importation, l'exportation et la constitution de réserves de drogues.[54] On maintenait le régime de certification des importations créé dans le cadre de la Convention de Genève de 1925, les parties devaient attribuer des permis à tous les fabricants, commerçants et distributeurs, et toutes les transactions relatives aux drogues devaient être documentées.[55] La Convention unique maintenait la tendance à exiger des parties qu'elles élaborent des lois criminelles de plus en plus punitives. Sous réserve de leurs restrictions constitutionnelles, les parties devaient adopter des infractions criminelles distinctes (punissables préférablement au moyen de l'incarcération) pour chacune des activités suivantes liées aux drogues et contrevenant à la Convention : la culture, la production, la fabrication, l'extraction, la préparation, la détention, l'offre, la mise en vente, la distribution, l'achat, la vente, la livraison (quelles qu'en soient les modalités), la facilitation de transactions, l'expédition, l'expédition en transit, le transport, l'importation et l'exportation.[56] De plus, l'approbation de l'extradition était jugée « souhaitable ».[57]

La Convention classait les substances dans quatre tableaux, selon le niveau de contrôle. Les tableaux I et IV comptaient les substances soumises au contrôle le plus rigoureux, principalement les matières organiques brutes (l'opium, le coca, le cannabis) et leurs dérivés, tels que l'héroïne et la cocaïne. Les tableaux II et III comptaient les substances soumises à des contrôles plus souples, principalement les drogues de synthèse à base de codéine. Sur l'insistance des États-Unis, on a placé le cannabis sous le régime de contrôle le plus sévère, celui du tableau IV. Ce régime englobait des drogues comme l'héroïne (selon l'OMS, toute application médicale de l'héroïne était « désuète »). L'argument justifiant l'insertion du cannabis dans cette catégorie était son usage répandu. L'OMS a découvert plus tard que le cannabis pouvait avoir des applications médicales, mais la structure était déjà en place et aucune mesure internationale n'a été prise pour corriger cette anomalie.

Les États-Unis étaient satisfaits de la Convention unique, qui élargissait le contrôle de la culture du pavot d'opium, du coca et du chanvre, même si ce contrôle était moins sévère que les mesures négociées par Anslinger dans le cadre du Protocole

---

son entrée en vigueur. Il n'a pas réussi et, par la suite, son influence s'est atténuée (Bewley-Taylor (1999) *op. cit.*, page 136-161).

[53] Seule la Convention pour la répression du trafic (1936) n'a pas été incluse dans la Convention unique et est demeurée en vigueur de manière autonome parce qu'on n'a pu s'entendre sur les dispositions à inclure dans la Convention unique (McAllister (2000) *op. cit.*, pages 207-208). L'article 35 de la Convention unique encourageait simplement la coopération entre les pays pour contrer le trafic illicite.

[54] Convention unique, articles 19 et 20.

[55] *Ibid.*, articles 21, 29-32

[56] *Ibid.* article 36

[57] *Ibid.*, paragraphe 36(2).

de l'opium de 1953.[58] Les articles 23 et 24 de la Convention établissaient des monopoles d'opium nationaux et imposaient des restrictions très strictes au commerce international de l'opium.

L'article 49 de la Convention exigeait que les parties abolissent entièrement, dans un délai maximal de 25 ans après l'entrée en vigueur de la Convention, tous les usages quasi-médicaux de l'opium,[59] la consommation d'opium, la mastication de la feuille de coca et l'usage non médical du cannabis. Toute production ou fabrication de ces drogues devait également être abolie à l'intérieur du même délai. Seules les parties pour lesquelles de tels usages étaient «traditionnels» pouvaient se prévaloir de la mise en oeuvre reportée ; pour les autres, la prohibition entrait en vigueur immédiatement. Puisque le délai maximal s'est écoulé en 1989, ces pratiques sont aujourd'hui entièrement interdites et les drogues peuvent servir uniquement à des fins médicales et scientifiques réglementées.

En plus de consolider les traités antérieurs et d'élargir les dispositions de contrôle, la Convention unique rationalisait les organismes des Nations Unies chargés de la lutte antidrogues. Le CCOP et l'OCS furent combinés en un nouvel organe, l'Organe international de contrôle des stupéfiants (OICS), responsable de surveiller l'application de la Convention et d'administrer le régime des estimations et des rapports statistiques soumis annuellement par les parties.[60] L'OICS devait compter onze membres, trois désignés par l'OMS et huit par les parties à la Convention et les membres de l'ONU. L'efficacité du lobby des fabricants durant les négociations était reflétée dans les connaissances requises des candidats de l'OMS : [Traduction] « *une expérience de la médecine, de la pharmacologie ou de la pharmacie* ».[61] L'OICS détenait un pouvoir limité de décréter des embargos qui lui permettait de recommander aux parties d'interrompre le commerce international de drogues avec tout État signataire qui ne se conformait pas aux dispositions de la Convention.[62]

Le peu d'attention consacrée aux problèmes de la toxicomanie reflétait à quel point la Convention était axée sur la prohibition. Seul l'article 38 abordait l'aspect social (l'élément «demande ») du problème, en exigeant que les parties [Traduction] « *accordent une attention spéciale à la mise en place d'établissements pour le traitement médical, les soins et la réadaptation des toxicomanes* ». De plus, on jugeait « souhaitable » que les parties [Traduction] « *mettent sur pied des installations adéquates pour le traitement efficace des toxicomanes* », mais seulement si le pays était aux prises avec [Traduction] « *un problème sérieux de toxicomanie et si ses ressources économiques le permett[ai]ent* ». La reconnaissance inadéquate des approches visant à réduire la demande et les effets nocifs, telles que la prévention au moyen de la sensibilisation, est un des principaux reproches faits à la

---

[58] Convention unique, articles 22-28.

[59] La limite était de 15 ans pour les usages quasi-médicaux de l'opium.

[60] Convention unique, articles 5, 9-16.

[61] *Ibid.*, alinéa 9(1)a).

[62] *Ibid.*, paragraphe 14(2).

Convention unique et, de manière générale, aux traités sur le contrôle international des stupéfiants.[63]

La Convention unique regroupait efficacement divers mécanismes de contrôle des stupéfiants, élaborés sur plusieurs décennies, en un seul document central administré par une organisation centrale – les Nations Unies.

Convention sur les substances psychotropes

Au cours des années 1960, après la signature de la Convention unique, il y a eu explosion de la consommation de drogues et de la toxicomanie partout dans le monde, notamment dans les pays occidentaux industrialisés.[64] Cette croissance se reflétait particulièrement dans l'usage et la disponibilité très répandus de substances psychotropes synthétiques créées depuis la Deuxième Guerre mondiale, telles que les amphétamines, les barbituriques et le LSD. La plupart de ces drogues n'étaient pas assujetties au contrôle international et, comme les systèmes de réglementation nationaux variaient énormément, le trafic et la contrebande prospéraient.[65]

Tout le long des années 1960, la Commission des stupéfiants et l'OMS ont discuté du contrôle des drogues psychotropes à leurs réunions régulières et ont présenté diverses recommandations aux pays membres concernant le contrôle national de substances précises, notamment les stimulants, les sédatifs et le LSD. En janvier 1970, la Commission des stupéfiants a discuté d'un traité préliminaire sur le contrôle international des drogues psychotropes, préparé par la Division des stupéfiants des Nations Unies. À la suite de quelques modifications apportées par la Commission des stupéfiants, ce document a servi de point de départ aux négociations de la conférence des plénipotentiaires qui a eu lieu à Vienne le 11 juillet 1971 – la conférence qui a mené à la Convention sur les psychotropes.[66]

La Convention unique de 1961 avait servi de modèle à la version préliminaire de la Convention sur les psychotropes, si bien que de nombreuses caractéristiques de la première se retrouvent dans la seconde : l'autorité administrative de la Commission des

---

[63] Voir, par exemple, *Report of the International Working Group on the Single Convention on Narcotic Drugs, 1961*, Toronto, Fondation de la recherche sur la toxicomanie, 1983, pages 10-11; recommandations 4, 5, 15, 19, 20.

[64] Voir, par exemple, Kušević, V., (1977) « Drug Abuse Control and International Treaties », *Journal of Drug Issues*, vol. 7, nº 1, pages 35-53. Voir aussi McAllister (2000) *op. cit.*, pages 218-220; Musto (1999) *op. cit.*, ch. 11; McAllister (1992) *op. cit.*, pages 153-162; Bruun *et coll.*, (1975) *op. cit.*, ch. 16; Inglis (1975) *op. cit.*, ch. 13.

[65] Les États-Unis ont tenté de réglementer les substances psychotropes par l'entremise du Bureau of Drug Abuse Control, créé par la *Drug Abuse Control Act of 1965*. Cette loi marquait aussi un virage sur le plan du fondement constitutionnel de la lutte antidrogues : on passait du pouvoir de taxation aux pouvoirs inter-états et commerciaux – un changement qui a entraîné l'abolition du Federal Bureau of Narcotics d'Anslinger et la création du Bureau of Narcotics and Dangerous Drugs (BNDD), relevant du ministère fédéral de la Justice (Musto (1999) *op. cit.*, pages 239-240).

[66] Kušević (1975) *op. cit.*, page 38.

stupéfiants/OICS, les tableaux établissant les différents niveaux de contrôle imposés aux différentes drogues, la documentation et la réglementation (au moyen de permis) obligatoires des transactions, un régime de contrôle des importations/exportations, ainsi que des dispositions touchant le trafic illicite et les sanctions criminelles. Une lecture superficielle pourrait laisser croire qu'il y a peu de différences entre les deux Conventions, mais elles sont en fait extrêmement différentes. La Convention sur les psychotropes impose des contrôles beaucoup plus souples. La raison de cet assouplissement devient évidente lorsqu'on prend connaissance des positions des intervenants négociateurs et qu'on compare attentivement certaines sections des deux traités.[67] L'influence dominante de l'industrie pharmaceutique multinationale sur la Convention des psychotropes était particulièrement perceptible.[68]

Alors que cinq groupes de négociation avaient été recensés par McAllister à la Convention unique, il y avait à la conférence de Vienne deux groupes distincts prônant des positions contraires. Le premier comptait surtout des pays industrialisés possédant de puissantes industries pharmaceutiques et des marchés actifs pour les substances psychotropes – il correspondait essentiellement au « groupe des fabricants ». Le second groupe était constitué de pays en voie de développement, appuyés par les pays socialistes, possédant peu d'usines de fabrication de substances psychotropes – il s'agissait dans une large mesure du «groupe des producteurs de la matière première organique ». Toutefois, aux négociations de 1971, les positions de ces deux groupes étaient *entièrement inversées.* Le groupe des fabricants a adopté les arguments traditionnels du groupe des producteurs organiques : des contrôles souples ; des contrôles nationaux (plutôt qu'internationaux) ; la préséance de la souveraineté nationale sur un organe supranational des Nations Unies. On justifiait ces positions en avançant que des contrôles stricts seraient difficiles à appliquer et entraîneraient des pertes financières. De son côté, le groupe des producteurs de matières premières organiques exerçait de fortes pressions en faveur de l'adoption de contrôles semblables à ceux qu'il avait dû accepter dans le cadre de la Convention unique.[69]

---

[67] McAllister (1992) *op. cit.*, pages 154-162; Kuševic (1975) *op. cit.*, pages 38-41. La comparaison de McAllister est très détaillée et nous la recommandons; Kuševic ajoute une mise en contexte et des commentaires utiles. Voir aussi S.K. Chatterjee, (1988) *A Guide to the International Drugs Conventions*, Londres, Commonwealth Secretariat, p. 15-33, pour une comparaison plus technique et de base des deux Conventions.

[68] L'auteur principal de la version préliminaire, Arthur Lande, avait mis fin à sa carrière à l'ONU peu avant la conférence de Vienne. Il a assisté à la conférence à titre de représentant de la Pharmaceutical Manufacturer's Association des États-Unis, un des nombreux observateurs associés à l'industrie. Voici un autre exemple de l'influence non équivoque de l'industrie : un groupe de six petits pays de l'Amérique latine ont appuyé, contrairement à leurs positions habituelles, l'affaiblissement du traité; ces pays étaient tous représentés par un Suisse qui maîtrisait mal l'espagnol et n'était ni agent gouvernemental, ni diplomate, ni spécialiste technique des stupéfiants. Il était au service du géant pharmaceutique européen Hoffmann-LaRoche (McAllister (2000) *op. cit.*, page 232; Kuševic (1975) *op. cit.*, page 39).

[69] McAllister (1992) *op. cit.*, page 154; Kuševic (1975) *op. cit.*, page 39.

Une comparaison des préambules des deux conventions est révélatrice. Bien que le préambule ne comporte pas de mesures exécutoires, il donne un aperçu de l'esprit du traité. Dans la Convention unique, la toxicomanie est décrite comme [Traduction] « *un fléau pour l'individu [...] un danger économique et social pour l'humanité* ». On reconnaît toutefois que [Traduction] « *l'usage de stupéfiants à des fins médicales demeure indispensable pour soulager la douleur et que les mesures voulues doivent être prises pour faire en sorte que les stupéfiants soient disponibles à cette fin* ». Par contraste, la Convention sur les psychotropes n'évoque pas « le fléau » de la toxicomanie, mais signale plutôt [Traduction] « *avec préoccupation les problèmes sociaux et de santé publique découlant de l'abus de certaines substances psychotropes* ». De plus, on reconnaît que [Traduction] « *l'usage de substances psychotropes à des fins médicales et scientifiques est indispensable et leur disponibilité à ces fins ne devrait pas faire l'objet d'une restriction injustifiée* ». Le ton général du préambule de la Convention sur les psychotropes est moins dur et laisse sous-entendre que l'abus de certains psychotropes (mais pas tous) n'est pas un problème aussi sérieux que l'accoutumance aux stupéfiants en général.

Il y a également des différences entre les deux conventions dans l'approche de la classification des drogues (qui se fait au moyen de tableaux associés à des niveaux de contrôle). Durant les négociations de la Convention unique de 1961, s'il y avait un désaccord relativement au placement d'une drogue dans un tableau particulier, cette drogue figurait presque toujours dans le tableau contesté par le groupe des producteurs des matières premières – par exemple, le placement du cannabis dans le tableau IV. Pour imposer ces assignations, le groupe des fabricants s'appuyait sur le principe suivant : il faut supposer qu'un stupéfiant est dangereux jusqu'à preuve du contraire. Toutefois, ce même principe ne s'appliquait pas lorsque les intérêts économiques des États-Unis étaient en jeu : en 1971, la délégation américaine a fait valoir avec force (et souvent avec succès) que les matières premières organiques devaient être assignées aux tableaux comportant les contrôles les plus sévères, tandis que leurs dérivés de synthèse devaient être placés dans les tableaux à réglementation souple.

La Convention sur les psychotropes comporte aussi quatre tableaux de contrôle, mais ils diffèrent considérablement des tableaux de la Convention unique en ce qui a trait à leur nature et à leur organisation. Par exemple, dans la Convention unique, le tableau comportant les contrôles les plus rigoureux est le tableau IV,[70] qui est équivalent au tableau I[71]de la Convention des psychotropes. Dans les deux cas, l'usage des drogues visées est restreint à des personnes autorisées au sein d'établissements médicaux ou scientifiques gouvernementaux, et leur fabrication, leur importation et leur exportation sont strictement contrôlées. Dans la Convention sur les psychotropes, le tableau comportant les contrôles les plus faibles est le tableau IV, qui comprend les tranquillisants. Certains États fabricants ont tenté d'abolir le tableau IV, en faisant valoir que les contrôles nationaux assuraient une réglementation adéquate de ces drogues, si bien que le contrôle international était inutile. En fin de compte, le

[70] Qui inclut le cannabis et l'héroïne, par exemple.
[71] Qui inclut les hallucinogènes, tels que le LSD.

tableau IV a été maintenu, mais avec une liste de drogues beaucoup plus courte ; le principe fondamental utilisé en 1961 pour assigner les drogues aux tableaux avait été complètement inversé, particulièrement chez les Américains : [Traduction] « *à moins de preuves convaincantes qu'une substance était nocive, elle ne devait être pas soumise à la réglementation* ».[72]

Une comparaison attentive des tableaux met en lumière une autre différence centrale entre les deux conventions. Les traités antérieurs, y compris la Convention unique, ne consignaient pas seulement les substances de base, mais élargissaient le contrôle de manière à inclure aussi leurs sels, leurs esters, leurs éthers et leurs isomères – autrement dit, leurs dérivés. Cependant, les dérivés sont *complètement absents* des tableaux de la Convention sur les psychotropes. Par conséquent, chaque substance visée par le régime de contrôle du traité doit être nommée explicitement. Sur le plan pratique, une telle énumération est impossible, car de nouveaux dérivés sont créés régulièrement et ils représentent 95 % des substances créées par les entreprises pharmaceutiques. Une inclusion générale des dérivés aurait eu pour effet d'inclure automatiquement les nouvelles substances. Il semble que cette omission était le fruit d'une entente entre les représentants politiques, à un moment où les spécialistes techniques étaient absents – il fallait sacrifier les dérivés pour que les pays fabricants acceptent de signer le traité.[73]

L'article 19 de la Convention unique établit le système des estimations. Ce système oblige les parties à soumettre à l'OICS un rapport annuel signalant la quantité de chaque substance réglementée dont elles auront besoin au cours de l'année à venir. Ce système est un des piliers du régime de contrôle international des stupéfiants et remonte à la deuxième conférence de Genève, qui a mené à la *Convention internationale de l'opium* de 1925. Ce système a été *complètement exclu* de la Convention sur les psychotropes. Comme le souligne McAllister : [Traduction] « *cette omission était nettement avantageuse pour les pays fabricants, puisqu'en l'absence de prévisions des besoins, il est impossible de déterminer si on fabrique une quantité supérieure aux applications prévues* ».[74] Cela a permis aux multinationales de produire des quantités illimitées de substances psychotropes sans avoir à tenir compte de limites de production annuelles fondées sur les besoins licites.

Au cours des années 1970 et 1980, la Division des stupéfiants et l'OICS ont dans une large mesure corrigé les omissions touchant les dérivés et les estimations, en ayant recours discrètement au droit international coutumier. La Division des stupéfiants et l'OICS ont demandé aux parties de soumettre de l'information et des statistiques dont la divulgation n'était pas requise par la Convention. Les réponses positives reçues des pays producteurs de matières premières organiques ont servi à convaincre les autres pays d'emboîter le pas. De même, la Commission des stupéfiants et l'OMS ont simplement annoncé que les dérivés seraient inclus dans les tableaux. Certains

---

72 McAllister (1992) *op. cit.*, page 158.
73 McAllister (2000) *op. cit.*, page 233.
74 McAllister (1992) *op. cit.*, page 157.

gouvernements se sont conformés à la mesure et les autres, en raison de la pression internationale, ont dû s'y plier à leur tour.

En vertu de l'article 3 de la Convention unique, il incombe principalement à l'OMS de déterminer si, à la lumière d'une analyse médicale ou scientifique, une nouvelle drogue devrait être ajoutée à un tableau et, par conséquent, soumise au contrôle international. La recommandation de l'OMS est présentée à la Commission des stupéfiants, qui prend la décision finale. Toutefois, toute partie peut porter en appel la décision de la Commission des stupéfiants auprès du Conseil économique et social dans un délai de 90 jours. La décision du Conseil économique et social est finale. Pendant qu'une décision est portée en appel, la Commission des stupéfiants peut tout de même imposer des mesures de contrôle relatives à la substance concernée.

En vertu de la Convention sur les psychotropes, l'OMS formule encore des recommandations en se fondant sur des critères médicaux et scientifiques. Toutefois, le paragraphe 2(5) demande explicitement à la Commission des stupéfiants de garder à l'esprit les facteurs économiques, sociaux, juridiques, administratifs et autres qu'elle pourrait juger pertinents en prenant une décision. De plus, le paragraphe 17(2) dispose que la décision de la Commission des stupéfiants est assujettie à l'approbation d'une majorité des deux tiers de ses membres.[75] Il est encore possible de porter la décision de la Commission en appel auprès du Conseil économique et social, et les parties disposent d'un délai de 180 jours pour déposer l'appel. En outre, la décision du Conseil économique et social n'est pas nécessairement finale – il y a la possibilité d'appels continuels. Enfin, pendant qu'une décision est portée en appel, le paragraphe 2(7) permet à une partie d'adopter une « mesure exceptionnelle » et de s'exempter de certaines mesures de contrôle imposées par la Commission des stupéfiants, en attendant le résultat de l'appel. L'effet cumulatif de tous ces ajouts à la Convention sur les psychotropes est qu'il peut être beaucoup plus difficile pour l'OMS d'assujettir une nouvelle drogue psychotrope au système de contrôle que d'ajouter un nouveau stupéfiant à la Convention unique.

Les deux conventions divergent aussi pour ce qui est des critères régissant l'inscription d'une nouvelle drogue au régime de contrôle. Selon l'article 3 de la Convention unique, un stupéfiant est soumis au régime de contrôle s'il est [Traduction] « *susceptible de donner lieu à des abus analogues et de produire des effets nocifs analogues à ceux des stupéfiants* » des tableaux pertinents. Les critères requis en vertu du paragraphe 2(4) de la Convention sur les psychotropes sont considérablement plus rigoureux. L'OMS doit constater :

> [Traduction]
> *(a)* *que la substance est apte à engendrer :*
> *(i) (1) un état de dépendance,*

---

[75] Les États-Unis ont tenté d'augmenter cette majorité aux trois quarts (McAllister, (2000) *op. cit.*, page 161).

> (2) *et une stimulation ou une dépression du système nerveux central, entraînant des hallucinations ou des perturbations de la fonction motrice ou de la réflexion ou du comportement ou de la perception ou de l'humeur,*
>
> (ii) *ou un abus analogue ou des effets nocifs analogues à ceux d'une substance inscrite au Tableau I, II, III ou IV,*
>
> *et qu'il y a suffisamment de preuves que la substance fait l'objet d'un abus ou fera probablement l'objet d'un abus, au point de constituer un problème social ou de santé publique justifiant que la substance soit placée sous contrôle international.*

Assumant un rôle de premier plan pour le groupe des fabricants sur ce point, les États-Unis et la Grande-Bretagne ont été les plus ardents défenseurs de ces critères très restrictifs.[76]

En ce qui concerne l'élément «demande» des problèmes liés aux drogues, la Convention sur les psychotropes devance nettement la Convention unique, qui abordait la question de manière superficielle (l'article 38 décrit ci-dessus). L'article 20 du traité de 1971 marque un tournant puisqu'il introduit le principe de la sensibilisation publique et de la prévention de la toxicomanie dans l'infrastructure juridique du contrôle international des stupéfiants. En particulier, on demande aux parties [Traduction] « *de mettre en place toutes les mesures pratiques possibles pour la prévention de l'abus des substances psychotropes et pour le dépistage précoce, le traitement, la sensibilisation, l'aide postpénale, la réadaptation et la réintégration sociale des personnes concernées, et de coordonner leurs efforts à ces fins* ». On exige de favoriser «dans la mesure du possible » la formation du personnel chargé de mener à bien ces tâches et on encourage également l'étude des questions étiologiques liées à la toxicomanie et la sensibilisation publique à ces questions. Bien que ces dispositions accordent une grande marge de manœuvre aux pays qui voudraient éviter de telles mesures, elles constituent une nette amélioration par rapport à la Convention unique.

Les dispositions pénales exposées à l'article 22 de la Convention sur les psychotropes permettent aux États de recourir au traitement, à la sensibilisation, à l'aide postpénale, à la réadaptation et à la réintégration sociale au lieu de s'en tenir uniquement à la condamnation ou à la punition à l'endroit des toxicomanes qui commettent des infractions à la Convention. Bien que la reconnaissance du traitement et de la réadaptation soit une amélioration par rapport aux dispositions strictement pénales des traités antérieurs, il s'agit avant tout de mesures complémentaires – et non de solutions de rechange – à l'incarcération.[77]

Dans l'ensemble, les négociations de 1971 ont mené à un traité considérablement plus faible que la Convention unique. De plus, un réexamen des dispositions de la

---

[76] *Ibid.*, page 159.

[77] Nations Unies, Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Done at Vienna on 20 December 1988, New York, Nations Unies, 1976, pages 353-354.

Convention sur les psychotropes n'était pas réaliste au début des années 1970, car un nouveau chapitre la « *war on drugs* » – la lutte antidrogues américaine – s'amorçait.[78]

Protocole portant amendement à la Convention unique sur les stupéfiants de 1961

Au début des années 1970, le président américain Richard Nixon a déclaré officiellement une «guerre contre les drogues» en réaction à l'ampleur de l'abus des drogues aux États-Unis et aux dommages sociaux qui en découlaient. Cette annonce a eu des répercussions mondiales.[79]

En 1971, dans le cadre de la campagne internationale de l'administration Nixon contre les stupéfiants, les représentants américains ont suggéré la création d'un fonds, administré par l'ONU et financé par les gouvernements, pour lutter contre l'abus des drogues.[80] Le Fonds des Nations Unies pour la lutte contre l'abus des drogues (FNULAD) a vu le jour en 1971, grâce à un don de 2 millions $ des Etats-Unis ; les autres gouvernements hésitaient à contribuer à leur tour, en raison des motifs qui sous-tendaient la création du Fonds. Leur réticence s'est avérée fondée, car le FNULAD est devenu essentiellement un outil américain. L'accent était mis sur la répression criminelle et la substitution des récoltes – plutôt que sur la toxicomanie et les stratégies axées sur la demande. L'argent était attribué avant tout aux projets auxquels participaient les alliés américains et qui ciblaient des pays où les États-Unis n'avaient pas réussi à arrêter la production d'opium.[81]

---

[78] On considère que la lutte antidrogues américaine a commencé avec l'adoption d'une loi antidrogues fédérale, la *Harrison Narcotics Act of 1914*, et qu'elle s'est poursuivie jusqu'à ce jour, à divers degrés d'intensité. Parmi les plus récents adeptes de cette lutte, mentionnons le président Nixon à la fin des années 1960 et au début des années 1970, le président Ronald Reagan durant les années 1980, le président George Bush à la fin des années 1980 et au début des années 1990, le président Bill Clinton durant les années 1990, et maintenant le président George W. Bush. La documentation sur la « war on drugs » est volumineuse. Voir, par exemple, Belenko, S.R. (éd.) (2000) *Drugs and Drug Policy in America: A Documentary History*, Westport (Connecticut) : Greenwood Press; Friman, H.R. (1996) *NarcoDiplomacy: Exporting the U.S. War on Drugs*, Ithaca (N.Y.) : Cornell University Press; Inciardi, J.A. (1986) *The War on Drugs: Heroin, Cocaine, Crime, and Public Policy*, Palo Alto (Californie) : Mayfield Publishing Company; Meier, K.J. (1994) *The Politics of Sin: Drugs, Alcohol and Public Policy*, Armonk (New York) : M.E. Sharpe; Musto (1999) *op. cit.*; Walker III, W.O. (1989) *Drug Control in the Americas*, édition révisée, Albuquerque (Nouveau-Mexique) : University of New Mexico Press; Wisotsky, S., (1990) *Beyond the War on Drugs: Overcoming a Failed Public Policy*, Buffalo (New York) : Prometheus Books.

[79] Musto (1999) *op. cit.*, pages 248-259; Bruun *et coll.*, (1975) *op. cit.*, ch. 10.

[80] La campagne américaine comportait un financement international massif pour la substitution des cultures, l'aide technique pour améliorer l'administration et l'application des lois, des initiatives anticontrebande, ainsi que la coordination des programmes d'éducation. Toutefois, de nombreux pays en voie de développement se méfiaient des fonds américains auxquels des conditions étaient rattachées. Aux yeux des Américains, le Fonds était un moyen de contourner cette réticence (McAllister (2000) *op. cit.*, pages 236-237).

[81] *Ibid.*, page 238.

Le Fonds a également fait l'objet de sérieuses critiques pour avoir succombé à l'inefficacité de la machinerie bureaucratique des Nations Unies : [Traduction] « *Une grande proportion des sommes allouées aux divers programmes du Fonds sert en fait à soutenir la bureaucratie en croissance permanente chargée d'administrer les programmes. De nombreux programmes semblent avoir pour unique fin de donner de l'ouvrage aux secrétariats élargis* ».[82] On a également avancé qu'il fallait transférer le FNULAD à des organes de contrôle des stupéfiants relevant du Conseil économique et social au Programme de développement des Nations Unies – un organisme mieux en mesure d'évaluer les besoins en matière de développement et d'aide des pays bénéficiaires.[83]

Une autre initiative clé de l'administration Nixon a été de renforcer la Convention unique. Un lobbying pressant des États-Unis a mené à la convocation d'une conférence de plénipotentiaires en mars 1972 en vue de modifier la Convention.[84] Le résultat de cette conférence a été le Protocole sur la Convention unique. L'objectif principal des modifications était d'élargir le rôle de l'OICS pour ce qui est du contrôle de la production licite et illicite d'opium et du trafic illicite des drogues en général. Les États-Unis voulaient remettre en place certains aspects du Protocole de l'opium de 1953 en tentant de réduire la production licite de l'opium. Toutefois, en 1972, la production licite répondait de manière assez juste à la demande licite, si bien que peu de pays étaient disposés à risquer une pénurie mondiale de l'opium destiné à des fins médicales.[85] Ainsi, on a considérablement atténué les propositions américaines.

Les dispositions centrales du Protocole sur la Convention unique sont celles qui augmentent les pouvoirs de l'OICS, particulièrement en ce qui a trait au trafic illicite. À l'article 2 de la Convention unique, la définition des fonctions de l'OICS comporte maintenant un renvoi explicite à la prévention de [Traduction] « *la culture, la production et la fabrication illicites ainsi que du trafic et de l'usage illicites de drogues* ». L'article 35 encourage les parties à soumettre à l'OICS et à la Commission des stupéfiants de l'information sur les activités liées aux drogues illicites à l'intérieur de leur territoire ; de plus, l'OICS est autorisé à conseiller les parties au sujet de leurs efforts en matière de réduction du trafic illicite de drogues. Lorsque les parties concluent des traités d'extradition entre elles, on considère que ces accords incluent automatiquement les infractions liées aux drogues – notamment le trafic – exposées dans la Convention unique.[86] Au paragraphe 22(2) de la Convention sur les psychotropes, il est seulement « souhaitable » que de telles infractions deviennent passibles d'extradition.

---

[82] Bruun *et coll.*, (1975) *op. cit.*, page 281.

[83] *Ibid.*, p. 282; Kuševic (1975) *op. cit.*, page 51

[84] Le choix des ambassadeurs américains s'est fait en fonction de la mission de se rendre dans les pays signataires pour convaincre leurs dirigeants d'appuyer les modifications proposées par les États-Unis. De l'avis général, la conférence était dans une large mesure un instrument dont Nixon prévoyait se servir dans les prochaines élections présidentielles (Kuševic (1975) *op. cit.*, page 47).

[85] Kuševic (1975) *op. cit.*, page 48. Selon Kuševic, il aurait été plus utile de chercher à réduire le *détournement* de la demande licite vers le marché illicite.

[86] Convention unique, article 36, modifié par le Protocole sur la Convention unique, article 14.

Le Protocole modifie les dispositions de la Convention unique portant sur la prévention de la toxicomanie, de manière à ce qu'elles reflètent les dispositions à l'article 20 de la Convention sur les psychotropes.[87] La version modifiée de la Convention unique reflète aussi la Convention sur les psychotropes en ce qu'elle permet désormais aux pays d'utiliser [Traduction] « *le traitement, la sensibilisation, l'aide postpénale, la réadaptation et la réintégration sociale* », soit à titre de solutions de rechange, soit à titre de mesures complémentaires à la condamnation ou à la punition.[88]

Bien que moins rigoureux qu'initialement prévu par les États-Unis, le Protocole sur la Convention unique maintenait la tradition prohibitionniste du régime de contrôle international des stupéfiants – particulièrement en ce qui a trait à l'opium – et intensifiait une fois de plus la lutte contre le trafic illicite.

Convention contre le trafic illicite de stupéfiants et de substances psychotropes

De nombreuses initiatives nationales et régionales de contrôle des stupéfiants ont débuté au cours des années 1970 et 1980.[89] En Europe, on a mis sur pied le Groupe de coopération en matière de lutte contre l'abus et le trafic illicite de stupéfiants, connu sous le nom de « Groupe Pompidou », qui était chargé de faciliter les discussions entre pays. De plus, les chefs d'organismes nationaux de répression des toxicomanies se sont réunis au palier régional – en Asie et dans le Pacifique, dans les années 1970, puis en Afrique, en Amérique latine et en Europe, dans les années 1980 – afin d'améliorer la coopération en matière de services policiers et de contrôle antidrogue aux douanes. INTERPOL a élargi ses activités et est devenue [Traduction] « *un important centre d'échange d'information et un parrain des réunions locales, régionales et mondiales consacrées à la lutte antidrogue* ».[90]

Pendant ce temps, au sein de l'ONU et chez ses principaux membres partisans du contrôle, on craignait que les efforts du régime de contrôle international des stupéfiants en vue de combattre le trafic illicite soient compromis du fait que certains États n'avaient pas adhéré aux Conventions ou n'avaient pas de système national de répression criminelle leur permettant de combattre adéquatement le trafic illicite des drogues.[91] En 1984, l'Assemblée générale des Nations Unies a adopté la

---

[87] *Ibid.*, article 38, modifié par le Protocole sur la Convention unique, article 15

[88] *Ibid.*, article 36, modifié par le Protocole sur la Convention unique, article 14

[89] Aux États-Unis, la lutte antidrogues a perdu de son intensité dans les années 1970 durant les mandats des présidents Gerald Ford et Jimmy Carter. Onze États américains ont décriminalisé certains aspects de la réglementation visant la marijuana ; ils ont obtenu l'appui d'organisations bien connues, notamment la American Medical Association, la American Bar Association, la American Public Health Association et le National Council of Churches. Le président Ronald Reagan a renversé cette tendance au début des années 1980 (Wisotsky (1990), *op. cit.*, page xviii).

[90] McAllister (2000) *op. cit.*, pages 242-243.

[91] Bewley-Taylor (1999) *op. cit.*, page 167; Stewart, D.P., (1990) « Internationalizing The War on Drugs: The UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances », *Denver Journal of International Law and Policy*, vol. 18, nº 3, printemps, pages 387-404.

résolution 39/141, appelant le Conseil économique et social à demander à la Commission des stupéfiants de préparer « *à titre de priorité* » une convention préliminaire envisageant [Traduction] « *les diverses facettes du problème [du trafic illicite des drogues] dans sa totalité et, en particulier, les facettes qui ne sont pas abordées dans les instruments internationaux existants* ». Ainsi, l'objectif était d'ajouter une dimension additionnelle, propre à la lutte contre le trafic, au régime de contrôle des stupéfiants, de manière à compléter les deux conventions existantes.

On a mis la dernière main au traité préliminaire durant la Conférence de 1987 des Nations Unies sur l'abus et le trafic illicite de drogue. Durant cette conférence, on a également adopté un Schéma multidisciplinaire complet pour les activités futures de lutte contre l'abus des drogues[92] (SMC), afin d'encourager les États à respecter leurs obligations en vertu des traités existants. Le SMC ciblait quatre secteurs : (1) la prévention et la réduction de la demande illicite ; (2) le contrôle de l'offre ; (3) la suppression du trafic illicite ; et (4) le traitement et la réadaptation. Bon nombre des objectifs exposés dans le SMC ont été repris dans le traité préliminaire. Entre le 25 novembre et le 20 décembre 1988, les représentants de 106 États se sont réunis à Vienne pour négocier un texte final. Le résultat a été la Convention contre le trafic illicite.

La Convention contre le trafic illicite est essentiellement un instrument de droit criminel international. Elle a pour objectif d'harmoniser les lois criminelles et les mesures de répression criminelle à l'échelle mondiale afin de réduire le trafic illicite de drogues grâce au recours à la criminalisation et aux sanctions. En vertu de la Convention, les parties sont tenues de créer et de mettre en oeuvre des lois criminelles très précises visant à supprimer le trafic illicite. Ces lois abordent des aspects du problème tels que le blanchiment de fonds, la confiscation de biens, l'extradition, l'assistance judiciaire réciproque, la culture illicite ainsi que le commerce des produits chimiques, matériaux et équipements servant à la fabrication de substances réglementées. Comme dans le cas des autres conventions, la Division des stupéfiants et l'OICS sont chargés de l'administration de la Convention. De plus, la Convention sur le trafic illicite permet l'utilisation de mesures associées à la «demande » – pour les infractions mineures – à titre de solution de rechange à la condamnation ou aux sanctions.[93]

Le préambule décrit le trafic illicite comme [Traduction] « *une activité criminelle internationale » et souligne « les liens entre le trafic illicite et d'autres activités criminelles organisées connexes qui minent les économies légitimes et menacent la stabilité, la sécurité et la souveraineté des*

---

[92] Déclaration de la Conférence sur l'abus et le trafic illicite de drogues et Schéma multidisciplinaire complet pour les activités futures de lutte contre les drogues, doc. de l'ONU ST/NAR/14, 1988.

[93] Pour une description détaillée des dispositions de la Convention contre le trafic illicite, voir Gilmore, W. (1990) *Combating International Drugs Trafficking: The 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, Londres : Secrétariat du Commonwealth; Stewart (1990) *op. cit.*.. Étant donné que Stewart était membre de la délégation américaine qui a participé aux négociations, son article présente la perspective américaine sur le traité.

États». Il met l'accent sur [Traduction] « *l'importance de renforcer et d'améliorer les moyens juridiques de coopération internationale dans le domaine criminel, en vue de réprimer les activités criminelles internationales liées au trafic illicite* ». Même l'unique renvoi à l'intérieur du préambule aux questions associées à la «demande» est formulé en termes propres au droit criminel : [Traduction] « *Désirant éliminer les causes profondes du problème de l'abus des stupéfiants et des substances psychotropes, y compris la demande illicite de ces stupéfiants et substances de même que les profits énormes découlant du trafic illicite* .» Par implication, les usagers de drogue doivent aussi être perçus comme des criminels. Le préambule reflète clairement ses racines prohibitionnistes – et même de manière explicite lorsqu'on y confirme [Traduction] « *les principes directeurs des traités existants visant les stupéfiants et les substances psychotropes, ainsi que le système de contrôle que ces traités concrétisent* ».

Ainsi, la pierre d'angle de la Convention contre le trafic illicite est l'article 3 : « Infractions et sanctions ». Ici, le traité innove en *exigeant* que les parties [Traduction] « *légifèrent, s'il y a lieu, en vue de mettre en place un code moderne d'infractions criminelles se rapportant aux diverses facettes du trafic illicite et d'assurer que de telles activités illicites seront traitées comme des infractions sérieuses par les autorités judiciaires* ».[94] Le paragraphe 3(1) expose les infractions obligatoires, notamment :

- La production, la fabrication, la distribution ou la vente de tout stupéfiant ou de toute substance psychotrope, en violation des dispositions de la Convention unique ou de la Convention sur les psychotropes ;
- La culture du pavot à opium, du coca ou du chanvre, en violation des Conventions ci-dessus ;
- La possession ou l'achat de tout stupéfiant ou de toute substance psychotrope pour le trafic illicite ;
- La fabrication, le transport ou la distribution de matériaux, d'équipement et de substances pour la culture, la production ou la fabrication illicites de stupéfiants ou de substances psychotropes ;
- L'organisation, la gestion ou le financement d'une des infractions ci-dessus.[95]

De plus, le paragraphe 3(2) de la Convention sur le trafic illicite exige que chaque partie – sous réserve de ses principes constitutionnels et des principes fondamentaux de son système juridique – crée des infractions criminelles pour la possession, l'achat ou la culture de drogues pour la consommation personnelle.

UNE MARGE DE MANŒUVRE ?

Posons d'abord quelques constats sur la substance des conventions en vigueur.

---

[94] Nations Unies, *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, Done at Vienna on 20 December 1988, New York, Nations Unies, 1976, page 48.
[95] Voir Stewart (1990) *op. cit.*, page 392; Gilmore (1991) *op. cit.*, page 5.

Le premier a trait à l'absence de définitions. Les termes drogues, stupéfiants, ou psychotropes ne sont pas définis sinon que par des listes de produits classés en tableaux. Il s'ensuit que « *est stupéfiant au sens du droit international, toute substance naturelle ou synthétique figurant sur la liste des stupéfiants* », de même que « *la notion de psychotrope est définie en droit international par l'appartenance à la liste des psychotropes* ».[96] La seule chose que nous révèle la Convention de 1961 des substances visées c'est qu'elles peuvent faire l'objet d'abus. La Convention de 1971 sur les psychotropes, dont on se souviendra qu'elle avait inversé les rôles puisque les pays fabricants des drogues synthétiques voulaient des critères moins englobant, indique que les substances visées peuvent provoquer la dépendance, la stimulation ou la dépression du système nerveux central, et qu'elles peuvent donner lieu à des abus « *tels qu'elle(s) constitue(nt) un problème de santé publique ou un problème social justifiant qu'elle(s) soi(en)t placé(es) sous contrôle international* ».

Le second, découlant du premier, souligne l'arbitraire des classifications. Stupéfiant figurant, en compagnie de l'héroïne et de la cocaïne, aux Tableaux I et IV – qui appellent les contrôles les plus sévères – de la Convention de 1961, le cannabis ne figure pas en soi à la Convention de 1971 mais le THC est un psychotrope qui figure au Tableau I en compagnie de la mescaline, du LSD, etc. Le seul critère apparent de distinction est celui de l'usage médical et scientifique, expliquant pourquoi les barbituriques se retrouvent au Tableau III de la Convention de 1971, soumis à des contrôles moins sévères que les hallucinogènes naturels… Non seulement ces classifications sont-elles arbitraires, mais de surcroît elles ne reflètent ni les classifications pharmacologiques des substances ni leur dangerosité sociale.

Troisième constat, si l'on s'était préoccupé des questions de santé publique en fonction de la dangerosité des « drogues », on doit se demander pourquoi le tabac et l'alcool ne figurent pas parmi les substances contrôlées.

De ces constats, nous émettons l'observation que le régime international de contrôle des substances psychoactives, au delà les fondements moraux et parfois racistes qui ont pu l'animer à ses débuts, **est surtout un système reflétant la géopolitique des relations Nord-Sud au cours du XXe siècle** : ce sont en effet les substances organiques – coca, pavot et cannabis – faisant souvent partie des traditions ancestrales des pays d'où originent ces plantes, qui ont fait l'objet des contrôles les plus sévères, tandis que les productions culturelles du Nord, tabac et alcool, ne s'y retrouvaient pas et que les substances synthétiques produites par les industries pharmaceutiques du Nord étaient, elles, l'objet d'un régime réglementaire et non d'un régime d'interdiction. Il faut bien comprendre en ce sens l'exigence du Mexique, au nom d'un groupe de pays latino-américains, à faire interdire l'usage lors des négociations de la Convention de 1988, exigence qui permettait de rétablir un certain équilibre, les pays du Sud ayant dû porter, depuis les débuts de la prohibition, tout le poids des contrôles et de leurs effets sur **leurs** populations. Le résultat est peut-être malheureux, puisqu'il renforce un régime prohibitionniste dont le XXe siècle a

[96] Caballero et Bisiou, *op. cit.*, : page 26.

amplement démontré l'échec ; mais c'était peut-être le seul moyen, tenant compte de l'État d'esprit des principales puissances occidentales, de démontrer à plus long terme l'irrationalité de tout le système. En tout état de cause, il n'y aurait qu'un pas à faire pour interroger la légitimité d'instruments qui contribuent à entretenir les inégalités Nord-Sud sans pour autant avoir réussi – loin de là – à réduire ni l'offre ni la demande de drogues.

Au delà de ce questionnement de fond, quelle est, à l'intérieur des conventions en place actuellement, la marge de manœuvre des pays pour adopter des politiques moins prohibitionnistes ?

Plusieurs États ont adapté leurs systèmes de répression criminelle de manière à permettre la possession *de facto* de faibles quantités de certaines drogues mineures – telles que le cannabis et ses dérivés – pour la consommation personnelle, tout en respectant les limites juridiques des conventions.[97] Bien que les conventions ne permettent pas la légalisation ou même la décriminalisation d'une telle possession, ces pays ont contourné les restrictions en criminalisant la possession (comme l'exigent les traités) mais en n'appliquant pas la loi de manière rigoureuse, ou encore ils ont « dépénalisé » les infractions en les exemptant des sanctions.[98]

Selon certains observateurs, de telles approches vont à l'encontre de l'esprit des conventions, particulièrement la Convention contre le trafic illicite, qui semble utiliser le terme « trafic » dans un sens très large englobant les activités liées à la « demande » à l'intérieur d'un régime de contrôle axé sur l'offre. Pourtant, il y a un fondement juridique sur lequel les approches plus souples pourraient prendre appui, car les traités ne les interdisent pas de manière explicite.

L'approche rigoureuse misant sur le droit criminel adoptée par le régime de contrôle international des stupéfiants a suscité des critiques chez les défenseurs des droits de la personne. Certains avancent que les sanctions d'emprisonnement sont disproportionnées quand il s'agit d'infractions liées aux drogues mineures, telles que la possession d'une faible quantité de cannabis pour la consommation personnelle.[99] Dans un tel contexte, l'incarcération serait une sanction démesurée par rapport à l'infraction commise et, par conséquent, constituerait une violation de la dignité

---

[97] Par exemple, la Belgique, le Danemark, l'Allemagne, les Pays-Bas et la Pologne, et certains états de l'Australie. La Suisse considère actuellement un projet de «légalisation » du cannabis. Le chapitre suivant présente plus en détail les approches australienne, néerlandaise et suisse notamment.

[98] Voir Krajewski, K., (1999) « How flexible are the United Nations drug conventions? », *International Journal of Drug Policy*, nº 10, pages 329-338. Krajewski présente un excellent survol des limites juridiques des conventions en ce qui a trait à la légalisation et à la prohibition. Il tire la conclusion que la légalisation ou la décriminalisation nécessiterait probablement la modification du paragraphe 3(2) de la Convention sur le trafic illicite. Voir aussi la discussion au sujet de la légalisation dans Dupras (1998) *op. cit.*, pages 24-33; et Noll, A., (1977) «Drug abuse and penal provisions of the international drug control treaties », *Bulletin on Narcotics*, vol. XXIX, nº 4, octobre/décembre, pages 41-57.

[99] Voir, par exemple, les pages suivantes du site Web de Human Rights Watch, une organisation non gouvernementale de défense des droits de la personne : http://www.hrw.org/campaigns/drugs/ et http://www.hrw.org/worldreport99/special/drugs.html

inhérente des personnes, du droit de ne pas subir des peines cruelles et dégradantes, et du droit à la liberté, tels qu'exposés dans des instruments internationaux comme la *Déclaration universelle des droits de l'homme*, le *Pacte international relatif aux droits civils et politiques* et la *Convention contre la torture et autres peines ou traitements cruels inhumains ou dégradants*.[100] Certains ont aussi avancé que l'usage de drogues est un droit de la personne et qu'il faudrait l'inscrire dans la *Déclaration universelle des droits de l'homme*.[101]

La Convention contre le trafic illicite est la seule des trois conventions à aborder les droits de la personne. Le paragraphe 14(2) de la Convention contre le trafic illicite oblige explicitement les parties à « respecter les droits fondamentaux de l'homme » lorsqu'elles adoptent des mesures en vue de prévenir et d'éliminer la culture illicite de plantes contenant des substances narcotiques ou psychotropes, telles que le pavot, le cannabis et le coca. La même disposition oblige les États à tenir compte des usages licites traditionnels – lorsqu'il existe des preuves historiques de tels usages – et de la protection de l'environnement.

Soulignons trois éléments qui donnent aux États, au Canada inclus, une certaine marge de manœuvre. Le premier est que les conventions reconnaissent la primauté des systèmes juridiques nationaux. En fait, les conventions internationales sur les stupéfiants n'ont pas d'application directe en droit national. Pour leur donner force sur le territoire national, l'État doit adopter une loi, au Canada la Loi sur les drogues et autres substances contrôlées. Spécifiquement, les conventions stipulent diversement que les mesures proposées de pénalisation sont faites «sous réserves des dispositions constitutionnelles » ou « compte tenu des régimes constitutionnel, juridique et administratif» des parties. Au Canada, les dispositions de la *Charte canadienne des droits et libertés* ainsi que les interprétations qu'en donne la Cour suprême sont des pièces maîtresses à l'intérieur desquelles le pays peut interpréter les conventions internationales sur les drogues.

Le second élément, un peu plus technique, suggère que la pénalisation de la détention se limite à la détention en vue du trafic, notamment en vertu du fait que cette disposition figure entre deux articles portant sur le trafic et en raison d'une formulation antérieure de cette disposition.[102] La non pénalisation de la détention (possession) aux fins d'usage personnel ne serait donc pas, stricto sensu, interdite. C'est là notamment l'avis juridique d'un expert préparé à la demande de l'Office fédéral de la Santé publique de Suisse à l'occasion de son projet de loi sur la «légalisation » du cannabis : « une dépénalisation générale, prévue par la loi, de la consommation et de la culture à petite

---

[100] Le texte intégral de ces instruments internationaux est disponible à la page suivante du site Web du Haut Commissariat des Nations Unies aux droits de l'homme :
http://www.unhchr.ch/html/intlinst.htm

[101] Voir Van Ree, E., (1999) «Drugs as a Human Right », *International Journal of Drug Policy*, vol. 10, pages 89-98. Van Ree propose un nouvel article 31 de la *Déclaration universelle des droits de l'homme* : « Chacun a le droit d'utiliser les substances psychotropes de son choix ».

[102] Là dessus, voir Dupras, D., (1998) *op. cit.*

échelle de cannabis serait compatible avec les conventions »[103]. En ce qui concerne le commerce et l'approvisionnement, l'auteur écrit : «*Même si une réglementation du commerce du cannabis avec un régime de licences ne semble pas exclue pour autant, des problèmes d'ordre pratique demeurent : d'une part à cause des mécanismes de contrôle exigés par la Convention de 1961 et, d'autre part, parce que la communauté internationale interprète la convention de 1988 comme une obligation de punir le commerce.* »[104]

Enfin, le troisième élément est que ces conventions imposent des obligations morales aux États, non des obligations juridiques ou moins encore assorties de pénalités ou de sanctions en cas de contravention, et qu'elles prévoient aussi des mécanismes de demande de révision ou de modification.

CONCLUSIONS

Le cannabis, dont nous avons vu aux chapitres 5, 6, et 7 qu'il est largement consommé par les populations de par le monde, qu'il n'a pas les effets nocifs qu'on lui prête, et qu'il présente peu de risques pour la santé publique, ne mérite certainement pas de figurer aux tableaux des conventions avec les substances dites les plus dangereuses. Le cannabis présente même des applications thérapeutiques que les tribunaux canadiens ont reconnues. C'est pourquoi **nous recommandons que le Canada informe la communauté internationale d'une demande de déclassement du cannabis dans le cadre d'une approche de santé publique et qui s'accompagnerait de mesures rigoureuses de suivi et d'évaluation.**

Conclusions du chapitre 19

- **Les conventions internationales élaborées depuis 1912 n'ont pas permis de réduire l'offre de drogues alors qu'elles étaient soi-disant conçues dans cet esprit.**
- **Les conventions internationales constituent un régime à deux vitesses réglementant les produits synthétiques produits par les pays du Nord et prohibant les substances organiques produites dans les pays du Sud, sans aucune considération pour les dangers réels que présentent ces substances pour la santé publique.**
- **Le cannabis a été inclus dans les conventions internationales en 1925 sans aucune connaissance de**

[103] Peith, M., (2001) « Compatibilité de différents modèles de dépénalisation partielle du cannabis avec les conventions internationales sur les stupéfiants. » Avis juridique soumis à la demande de l'Office fédéral de la santé publique de la Confédération helvétique, page 14.
[104] *Ibid.*, page 15.

	ses effets. ➢ **Les classifications internationales des drogues sont arbitraires et ne reflètent pas la dangerosité des substances pour la santé ni pour la société** ➢ **Le Canada devrait informer la communauté internationale des conclusions de notre rapport et demander officiellement le déclassement du cannabis et de ses dérivés.**

CHAPITRE 20

POLITIQUES PUBLIQUES DANS D'AUTRES PAYS

Nous venons de voir que les conventions internationales encadrent les approches de politiques pénales que les États signataires peuvent adopter. Nous avons aussi vu que les interprétations varient quant à la nature de ces obligations, spécifiquement quant à la consommation et donc à la détention aux fins personnelles. Certaines interprétations vont jusqu'à suggérer que, en ce qui concerne le cannabis, certaines formes de réglementation de la culture pourraient être possibles sans par ailleurs contrevenir aux dispositions des conventions, pour autant que l'État prendrait les moyens nécessaires pour pénaliser les trafics illégaux.

La vaste majorité des Canadiens ont entendu parler de la « guerre à la drogue » que mènent les USA et de son approche prohibitionniste, mais plusieurs seront étonnés de constater les variations importantes entre états, voire entre villes, de la fédération. Moins nombreux sont ceux qui savent que la Suède suit une politique d'interdiction au moins aussi rigoureuse mais par d'autres moyens. Beaucoup d'entre nous avons déjà entendu parler, d'une manière ou d'une autre, de l'approche «libérale » implantée aux Pays-Bas depuis déjà 1976. Moins auront entendu parler des approches espagnole, italienne, luxembourgeoise, ou suisse qui sont, à certains égards, encore plus libérales. Plus récemment, les Canadiens ont pris connaissance de la décision du ministre de l'Intérieur du Royaume-Uni de « déclasser » le cannabis au tableau C ; mais il n'est pas certain que nous sachions bien ce que cela signifie. Tenant compte des préconceptions que l'on se fait de la France par rapport au vin, plusieurs pourront être étonnés d'apprendre que sa politique en matière de cannabis semble plus « conservatrice » que ne le serait celle, par exemple, de son voisin belge.

On voit qu'une fois posé le cadre global du casse-tête par la communauté internationale, les manières d'en agencer les morceaux varient largement entre les États parfois entre les régions d'un même État. C'est pourquoi, afin d'apprendre des expériences et approches des autres pays, le Comité a commandé un certain nombre de rapports de recherche sur la situation dans d'autres pays[1], et a souhaité entendre directement des représentants d'un certain nombre d'entre eux.[2]

---

[1] Ces rapports, préparés par les recherchistes de la Bibliothèque du Parlement, portent sur l'Australie, les États-Unis, la France, les Pays-Bas, le Royaume-Uni, la Suède et la Suisse. On en trouvera les références exactes à l'annexe 3.

[2] Nous avons entendu des représentants des États-Unis, de la France, des Pays-Bas et de la Suisse.

Évidemment, nous avons dû faire des choix. Nous nous sommes limités aux pays occidentaux du Nord ; c'est une faiblesse, nous en convenons, mais nos ressources étaient limitées. De surcroît, voulant mettre les politiques publiques en relation avec des données sur les tendances d'usage et les pratiques judiciaires, nous étions contraints de choisir des pays disposant d'une base d'informations. Quant aux audiences de représentants des pays, nous étions limités surtout par le temps.

Ce chapitre décrit la situation dans cinq pays européens soit en France, aux Pays-Bas, au Royaume-Uni, en Suède et en Suisse, ainsi qu'en Australie et aux USA.

FRANCE[3]

Des logiques distinctives

La «rupture » introduite par loi de 1970[4], en vigueur actuellement, qui pénalise l'usage de drogues, est à certains égards plus apparente que réelle. La politique publique *interne* avait en effet commencé à changer dès la fin du XIXe siècle menant à l'adoption de la grande loi sur les stupéfiants de 1916 qui pénalisait l'importation, le commerce, la détention et l'usage. Cette loi, d'application particulièrement sévère pour l'époque (jusqu'à 3 ans d'emprisonnement pour délits reliés aux stupéfiants) instituait le délit « d'usage en société ». Son adoption avait été précédée par une intense «campagne de salubrité publique » où les stupéfiants étaient «accusés par leurs détracteurs d'être à l'origine de la plupart des maux de la société, c'est-à-dire de favoriser en bloc la dépopulation, la décadence des mœurs ou bien encore les actes violents et criminels.»[5]

Cette loi sera complétée par la loi de 1922 et le décret loi de 1939 qui aggravent et renforcent ses prescriptions. La loi de 1922 imposait aux juges de prononcer l'interdiction de séjour contre les personnes convaincues de trafic ou de facilitation d'usage et la seconde augmentait les peines jusqu'à cinq ans. La loi de 1922 autorisait aussi la police à visiter des domiciles sans autorisation judiciaire préalable. De l'avis de Charras, «ces différentes prescriptions firent de la législation française l'une des plus draconiennes d'Europe. »[6]

Autre élément de tension dans la loi de 1970, l'injonction thérapeutique, considérée parfois comme le cœur même de la législation sur les drogues. Selon cette

---

[3] Pour cette section, nous avons bénéficié du rapport d'étude préparé par la Bibliothèque du Parlement : Collin, C., (2001) *Politique nationale en matière de drogues : France.* Ottawa : Bibliothèque du Parlement, rapport préparé pour le Comité spécial du Sénat sur les drogues illicites.

[4] Loi no 70-1320 du 31 décembre 1970 relative aux mesures sanitaires de lutte contre la toxicomanie et à la répression de trafic et de l'usage des substances vénéneuses.

[5] Charras, I., (1998) « L'État et les « stupéfiants » : archéologie d'une politique publique répressive. » in *Drogue. Du bon usage des politiques publiques. Les cahiers de la sécurité intérieure*, page 13.

[6] Charras, I., *op. cit.*, pages 15-16.

disposition, « *une obligation de soins peut être imposée à l'usager de stupéfiants à trois moments du processus pénal :*

- A l'entrée dans la partie judiciaire, le parquet peut proposer une alternative aux poursuites pénales ;
- En cours de procédure, le juge d'instruction ou le juge des enfants peut imposer la surveillance médicale ;
- Lors du prononcé du jugement, le tribunal peut imposer une mesure de soins, soit parce que l'usager l'a refusée auparavant, soit au contraire pour la prolonger si elle a démarré au titre de l'article précédent. »[7]

« *Contrepoids humaniste d'une politique répressive* »[8], l'injonction thérapeutique a souvent été caractérisée par divers observateurs français comme un compromis boiteux entre les pouvoirs policier d'un côté et médical de l'autre.[9]

Mais à caractériser le système français entre la répression de l'usager comme « délinquant » et son traitement comme «malade », il y a risque de gommer toute une autre partie de l'approche française en matière de drogues au moins jusqu'aux années 1970, sa politique *extérieure et la logique fiscale.*

> « *La prohibition des drogues est récente. Si on excepte la Chine qui cherche à prohiber l'usage de l'opium dès le XVIIIe siècle, il faut attendre le XXe siècle pour que la prohibition soit discutée en Europe. Encore ne devient-elle effective qu'après les années 50. Quant à la volonté de prendre en charge médicalement les usagers, elle n'est vraiment construite que depuis une vingtaine d'années. Avant d'être réprimé ou prescrit, l'usage de stupéfiants était taxé par le biais de monopoles fiscaux de l'opium ou du cannabis.* »[10]

Bisiou identifie cinq monopoles connus dans l'histoire de la France coloniale : ceux de l'Inde, de 1864 à 1954 ; ceux de l'Indochine de 1864 jusqu'en 1975 au Laos ; en Océanie de 1877 à 1922 ; et deux monopoles du cannabis exploités concurremment avec les monopoles du tabac, un en Tunisie entre 1881 et 1954, l'autre au Maroc, entre 1914 et 1952. Un autre, dont l'existence n'a pas été confirmée, aurait existé au Liban.[11]

Ces monopoles présentent divers avantages, notamment fiscaux et politiques. Au plan fiscal, ils constituent une rentrée importante de devises permettant de financer

---

[7] Simmat-Durand, L., (1999) « Les obligations de soins en France. » in Faugeron, C., (ed.) *Les drogues en France. Politiques, marchés, usages.* Paris : Georg éditeur, page 111.

[8] Setbon, M., (2000) *L'injonction thérapeutique. Évaluation du dispositif légal de prise en charge sanitaire des usagers de drogues interpellés.* Paris : Observatoire français des drogues et des toxicomanies, page 11.

[9] Voir entre autres Simmat Durand, L., (2000) *La lutte contre la toxicomanie. De la législation à la réglementation.* Paris : L'Harmattan ; Bernat de Celis, J., (1996) *Drogues : Consommation interdite.* Paris : L'Harmattan ; et Bergeron, H., (1996) *Soigner la toxicomanie. Les dispositifs de soins entre idéologie et action.* Paris : L'Harmattan.

[10] Bisiou, Y., (1999) « Histoire des politiques criminelles. Le cas des régies françaises des stupéfiants. » in Faugeron, C., (ed.) *Les drogues en France. Politiques, marchés, usages.* Paris : Georg éditeur, page 89.

[11] Bisiou, *op. cit.*, page 90.

l'entreprise coloniale ; au plan politique, ils sont bien acceptés par les colonies dans la mesure où ils préexistaient l'implantation française et étaient déjà bien acceptés par les populations locales. De manière intéressante, c'est le caractère moral des « substances vicieuses » qui justifie ce régime de taxation de produits de luxe dont on ne veut pas encourager la consommation. Abolie à la décolonisation, marquée par certaines contradictions internes entre des impératifs économiques de rentabilité et des objectifs sanitaires, cette politique avait aussi, à partir des années 30, fait l'objet de nombreuses critiques de la communauté internationale, dont les orientations étaient, on l'a vu, de plus en plus prohibitionnistes. N'empêche que l'histoire des monopoles d'État sur les drogues a marqué l'histoire française (comme la néerlandaise, la britannique et la portugaise d'ailleurs), et qu'elle constitue un autre pôle à côté de la politique intérieure.

Ainsi, ce n'est pas *une* politique publique qui a animé la France en matière de drogues au cours du XXe siècle, mais bien trois logiques souvent en concurrence les unes avec les autres. Il faut attendre le renforcement de la Mission interministérielle de lutte à la drogue et à la toxicomanie (MILDT) au milieu des années 1990 pour voir naître les velléités d'une politique d'ensemble plus intégrée, plus cohérente aussi.

Une politique publique intégrée

La MILDT avait été créée au début des années 80 sous le premier septennat Mitterrand. Mais au cours des ans, soit elle manquait de leadership, soit ses moyens n'étaient pas à la hauteur de ses ambitions. Il faut attendre la nomination de Nicole Maestracci en 1995, sous le gouvernement socialiste de Jospin, pour que la MILDT s'engage sur une trajectoire de visibilité et d'action publique forte. Son action a été aiguillée notamment par les controverses et manifestations virulentes d'intervenants de divers ordres (médecins hospitaliers préoccupés par le sida, membres d'ONG, toxicomanes, spécialistes, etc.) qui critiquaient les fondements scientifiques des principaux objectifs de la politique française en matière de drogues. Au centre de ce débat : la nécessité d'une approche de réduction des méfaits, ancrée sur la réduction de la transmission du sida par les usagers de drogues par intraveineuse et le traitement à la méthadone administré aux toxicomanes.[12]

En février 1994, seul un petit groupe de 77 toxicomanes avait accès à un traitement à la méthadone alors que la France comptait, à la même époque, 160 000 héro?nomanes. En 1998, des traitements de substitution de médicaments ont été offerts, en France, à un groupe pouvant atteindre 70 000 toxicomanes dont la grande majorité recevaient du Subutex et les autres de la méthadone.[13] Ce virage indique clairement que les pouvoirs publics considèrent maintenant la réduction des

[12] Voir Mme Nicole Maestracci, présidente de la Mission interministérielle de lutte à la drogue et à la toxicomanie, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 1er octobre 2001, fascicule no 7, pages 9-10.

[13] Michel Kokoreff, « Politique des drogues en France, entre loi pénale et réduction des risques », présentation au Comité sénatorial spécial sur les drogues illicites, 2001.

méfaits de la drogue comme un élément fondamental de la politique française en la matière.[14]

Le 16 juin 1999, le gouvernement français a présenté un plan triennal qui reflète clairement ce changement de paradigme puisque les mesures palliatives et préventives devenaient des buts légitimes dans le cadre de la politique française. En ce qui a trait à la politique pénale, le cadre législatif principal – la Loi de 1970 – n'a pas été modifié et la consommation de drogue est toujours tenue pour une infraction. Néanmoins, une circulaire du ministre de la Justice a invité les procureurs à éviter l'incarcération et à promouvoir le traitement dans les cas de consommation de drogue.

Le plan est fondé sur des données européennes et internationales autant que sur de récents rapports, des consultations interministérielles, et des études scientifiques fournissant un certain nombre d'observations fondamentales à propos de la politique en matière de drogues et de la toxicomanie en France. L'émergence de nouveaux profils de consommation tels que l'utilisation de drogues multiples (licites et illicites), l'augmentation de la consommation de cannabis et d'alcool chez les jeunes, et la disponibilité accrue de drogues de synthèse étaient au cœur des préoccupations exprimées. Les systèmes et les bases de connaissance ont également fait l'objet de diverses critiques :

- Le manque de coordination entre les programmes de prévention et leur accessibilité limitée (p. ex. les programmes de prévention scolaire en matière de drogue ne sont offerts qu'à moins de 40 % des élèves et, en ce qui concerne l'alcool et le tabac, à moins de 20 %) ;
- Le manque d'appui social et professionnel ;
- Le fait qu'il n'y ait pas de terrain d'entente culturel entre les divers intervenants (application des lois, bien-être social, éducation et santé publique);
- L'importance excessive accordée aux héroïnomanes dans l'administration des traitements spécialisés au moment même où la consommation, parmi les membres de ce groupe de toxicomanes, vient de se stabiliser ;
- La difficulté de concilier la mise en application de la loi avec une stratégie de santé publique.[15]

L'application de la loi pénale à l'égard des usagers a été constamment marquée par la difficulté à concilier action répressive et impératifs de santé publique. Le nombre d'usagers interpellés a doublé en cinq ans, sans que la procédure judiciaire permette suffisamment une rencontre utile avec médecins ou travailleurs sociaux.[16]

---

[14] Henri Bergeron, « Comment soigner les toxicomanes? », *Sociétal*, juin-juillet 1998, pages 45 à 49.

[15] Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT), *Plan triennal de lutte contre la drogue et de prévention des dépendances (1999-2001)*. Document disponible en ligne à l'adresse : http://www.drogues.gouv.fr/uk/what_you_need/whatyouneed_intro.html.

[16] Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT), « Livret de connaissances, Synthèse du plan gouvernemental de lutte contre la drogue et de prévention des

En outre, les représentants élus et le grand public, constatant la diminution du nombre d'arrestations pour trafic au niveau local depuis 1996, trouvent ce fait difficile à comprendre tenant compte de l'importance qu'il faudrait accorder, à leurs yeux, au contrôle de l'approvisionnement en drogues. Enfin, le manque d'indicateurs fiables a empêché toute évaluation approfondie, voire compréhensible, des programmes existants.

À partir de ces constats, le gouvernement a élaboré un plan triennal définissant les priorités d'action, les objectifs et les mesures à prendre. Au cœur de ce dispositif, deux mots clés : intégration et connaissance. Intégration vue sous au moins deux angles : pour la première fois, la France aura une politique intégrée sur l'ensemble des substances psychoactives, drogues, médicaments, alcool et tabac.

> *« Le fait qu'on ait parlé de l'alcool, du tabac, et des médicaments et ce, en même temps qu'on parlait de drogues, a fait sans doute que chacun s'en est senti plus proche puisque chacun avait l'expérience de la consommation d'un produit qu'il soit licite ou illicite. C'était un élément important qui ne nous conduisait pas à dire que tous les produits allaient avoir le même régime législatif mais (cela permettait, quel que soit le produit), de distinguer des usages occasionnels et des usages problématiques. »* [17]

L'autre aspect de l'intégration est celui d'une interministérialité renforcée entre les 19 ministères qui forment la MILDT sous la présidence du Premier ministre.

Le second mot clef au cœur du dispositif français est celui de la connaissance. Comme nous l'avons mentionné plus tôt, un certain nombre d'observateurs avaient noté les faiblesses de l'appareillage de connaissance, dont des rapports commandés par diverses instances (discutés infra). Dans la foulée de l'impulsion donnée par la présidence de François Mitterrand à la création de l'Observatoire européen des drogues et des toxicomanies, la France crée, en 1993, l'Observatoire français des drogues et des toxicomanies. Organisme « autonome », l'Observatoire a pour mission « de développer le réseau sentinelle afin d'observer les tendances récentes de consommation, de conduire des enquêtes épidémiologiques régulières en population et de mettre en place un cadre global d'évaluation des politiques publiques. »[18] Pour ce faire, il organise ses travaux sur trois axes principaux : la veille et l'amélioration des indicateurs ; la surveillance des tendances récentes et l'évaluation des politiques. L'observatoire dispose d'un personnel de 25 personnes et d'un budget de 18 millions FF (environ 3,5 millions $). Il est aussi le point de correspondance national au réseau de l'Observatoire européen des drogues et des toxicomanies.

---

dépendances 1999-2000-2001 », *Drogues : savoir plus, risquer moins*, MILDT, décembre 1999, page 7. Disponible en ligne à l'adresse http://www.drogues.gouv.fr/fr/index.html

[17] Nicole Maestracci, témoignage devant le Comité spécial du Sénat sur les drogues illicites, page 13.

[18] Observatoire français des drogues et des toxicomanies (2002) *Drogues et dépendances. Indicateurs et tendances 2002.* Paris : auteur, page 291.

Cadre législatif

La loi française qui régit les drogues illicites est tirée de nombreuses sources, notamment de quatre codes : le Code de la santé publique, le Code pénal, le Code de procédures pénales et le Code des douanes. Le cadre législatif principal est la loi du 31 décembre 1970, qui a amendé le Code de la santé publique et créé un cadre législatif fondé sur l'application de diverses mesures répressives et de dispositions relatives à la santé. La Loi de 1970 avait pour objet de réprimer sévèrement le trafic, d'interdire l'usage des stupéfiants tout en proposant une solution de rechange thérapeutique à la répression de l'usage, de même que d'assurer la gratuité des soins et l'anonymat pour les usagers qui souhaitent se faire traiter.[19] Il convient de noter que la plupart des articles de la Loi de 1970 (inscrits à l'origine dans le Code de la santé publique) ont été depuis intégrés au nouveau Code pénal entré en vigueur en 1994, à l'exception des infractions liées à la consommation des drogues, qui sont toujours sanctionnées par le Code de la santé publique. La loi française est également régie par la législation internationale depuis que la France a ratifié par voie législative les conventions des Nations Unies sur les stupéfiants.

Classes de drogues

La loi française ne distingue pas entre les types de drogues illicites ; par conséquent, une infraction telle que la consommation de drogue fait l'objet de poursuites et d'un jugement qui ne varient pas en fonction de la nature du produit consommé. Néanmoins, les autorités judiciaires peuvent tenir compte de la nature et de la quantité du produit, ainsi que de l'existence d'un casier judiciaire, dans leur décision d'intenter des poursuites, de réduire les accusations ou de ne pas inculper un délinquant. Les drogues illicites sont répertoriées dans des annexes de l'Arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants :

Annexe I :	Stupéfiants tels que l'héroïne, la cocaïne, le cannabis, la méthadone, l'opium, etc.;
Annexe II :	Les substances telles que la codéine, le propiram, etc.;
Annexe III :	Les substances psychotropes telles que les amphétamines, l'ecstasy, le LSD, etc.;
Annexe IV :	Les drogues synthétiques : le MBDB, la 4-MTA, la kétamine, le nabilone, THC, etc.[20]

---

[19] Observatoire français des drogues et des toxicomanies (OFDT), *Drogues et toxicomanies : indicateurs et tendances*, Édition de 1999, page 20. Disponible en ligne à l'adresse http://www.drogues.gouv.fr/fr/index.html.

[20] Observatoire européen des drogues et des toxicomanies (OEDT)/European Legal Database on Drugs (ELDD), *France Country Profile, French Drug Legislation*. Extrait du site http://eldd.emcdda.org/databases/eldd_national_reviews.cfm?country=FR.

Infractions et peines

L'usage public ou privé de drogue est interdit en France et criminalisé par la Loi de 1970 (article L3421-1 du Code de la santé publique). La peine maximale infligée pour l'usage d'une drogue illicite est un emprisonnement d'un an ou une amende de 25 000 FF, ou encore le renvoi à un programme thérapeutique sur ordonnance du tribunal (injonction thérapeutique). Cet article du Code de la santé publique s'applique à tous les usagers sans distinction quant à la nature de la substance illicite consommée.

Le Code de la santé publique assure également la surveillance des toxicomanes par les services de santé (article L3411-1). Il se peut que les procureurs de la République n'intentent pas de poursuites judiciaires contre un délinquant qui peut, sur la foi d'un certificat médical, prouver qu'il s'est engagé dans une forme quelconque de thérapie ou s'est soumis à une surveillance médicale depuis la perpétration de l'infraction. Toutefois, si une personne ayant fait usage d'une drogue illicite ne fournit pas de certificat médical à cet effet, les procureurs peuvent l'enjoindre de suivre une cure de désintoxication ou de se placer sous surveillance médicale (article L3423-1). La participation à un programme ordonné par un tribunal suspend les poursuites judiciaires et celles-ci seront abandonnées si la personne en cause suit le programme de désintoxication en entier.[21] Il n'est pas rare pour un récidiviste de se voir imposer plus d'un traitement par un tribunal puisqu'on fait rarement appel à des mesures plus répressives pour un simple usage de drogue, particulièrement s'il s'agit de cannabis.

Une directive du ministère de la Justice de juin 1999 a demandé aux procureurs de préférer le traitement à l'incarcération pour les petits délinquants et les toxicomanes qui causent problème. La pratique a démontré que la solution thérapeutique est utilisée principalement pour les délinquants qui ne font que consommer ; dans la plupart de ces cas, le délinquant reçoit un avertissement et est tenu de s'adresser à un service social ou à un dispensaire. Lorsque des poursuites judiciaires sont intentées, le magistrat peut également imposer – et non simplement ordonner – à l'accusé de s'inscrire à un programme de désintoxication ; dans un tel cas, ce sont les autorités judiciaires qui se saisissent du cas au lieu qu'il soit confié aux services de santé. Si l'usager termine le traitement, on peut ne lui infliger aucune peine, mais le recours à de telles mesures est extrêmement rare.[22] De la même façon, une intervention de désintoxication peut être une des conditions associées à une peine de prison avec sursis, à une mise en liberté conditionnelle ou à un régime de surveillance judiciaire. En France, le toxicomane est donc vu comme une personne malade à qui il convient d'offrir une thérapie.[23]

En ce qui a trait au trafic de stupéfiants, la Loi de 1970 a été modifiée à diverses reprises, créant de nouvelles infractions telles que la cession ou l'offre illicites de drogues pour usage personnel (17 janvier 1986), le blanchiment de l'argent de la drogue (31 décembre 1987), ou la promulgation de nouvelles procédures telles que la

---

[21] Comité consultatif national d'éthique, *Rapports sur les toxicomanies*, rapport no 43, le 23 novembre 994, page 19. Voir : http://www.ccne-ethique.org/français/start.htm

[22] OEDT/ELDD, France Country Profile, 2001.

[23] Comité consultatif national d'éthique, 1994.

confiscation des profits du trafic des stupéfiants (14 novembre 1990) en vue de se conformer à l'article 5 de la Convention des Nations Unies (19 décembre 1988).[24] Actuellement, les infractions de trafic comprennent la cession ou l'offre illicites de stupéfiants à une personne pour consommation personnelle et elles sont assorties d'une peine pouvant aller jusqu'à cinq ans d'incarcération et une amende maximale de 500 000 FF (articles 222-39 du Code pénal) ; et une infraction qui criminalise le transport, la détention, l'offre, la cession, l'acquisition ou l'emploi illicites de stupéfiants et qui est assortie d'une peine pouvant aller jusqu'à dix ans d'incarcération et d'une amende maximale de 50 millions FF (article 222-37). L'importation et l'exportation illicites de stupéfiants sont également punissables de dix ans d'incarcération et d'une amende pouvant aller jusqu'à 50 millions FF, mais quand cette même infraction est commise par une organisation criminelle, la peine peut aller jusqu'à 30 ans d'emprisonnement (article 222-36). En outre, le trafic des stupéfiants peut également être considéré comme une infraction douanière (contrebande et infractions similaires) entraînant une peine maximale de trois ans d'incarcération et des amendes pouvant représenter jusqu'à deux fois et demie la valeur de la marchandise illicite. Les poursuites intentées en vertu du Code des douanes n'excluent pas les poursuites au pénal et les sanctions pour les infractions à la réglementation douanière peuvent s'ajouter aux sanctions pénales.[25]

On peut citer, parmi les autres infractions, la production ou la fabrication illicites de stupéfiants, punissable de 20 ans d'emprisonnement et d'une amende de 50 millions FF. Ici encore, lorsqu'un membre d'une organisation criminelle commet l'infraction, la peine peut aller jusqu'à 30 ans d'incarcération (article 222-35). Le blanchiment d'argent ayant un rapport avec la drogue, défini comme « faciliter, par tout moyen, la justification mensongère de l'origine des liens ou des revenus de l'auteur d'une infraction à la loi sur les stupéfiants », est punissable d'une peine de 10 ans d'emprisonnement et d'une amende de 5 000 000 FF (article 222-38). La provocation à l'usage de drogue ou à la perpétration des infractions prévues par les articles 222-34 à 222-39 du code pénal ou le fait de présenter ces infractions sous un jour favorable est punissable de cinq ans d'incarcération et d'une amende de 500 000 FF (article L3421-4 du Code de la santé publique). Cette infraction vise les médias et les œuvres littéraires ou artistiques. Le fait de provoquer un mineur à faire usage illicite de stupéfiants est punissable de cinq ans d'emprisonnement et d'une amende de 700 000 FF, et, dans le cas d'un mineur de moins de 15 ans ou si l'infraction est commise à l'intérieur ou à

---

[24] Convention des Nations Unies contre le trafic illicite de stupéfiants et de substances psychotropes, 19 décembre 1988 : article 5, Confiscation. 1. Chaque partie adopte les mesures qui se révèlent nécessaires pour permettre la confiscation : a) des produits tirés d'infractions établies conformément au paragraphe 1 de l'article 3 ou des biens dont la valeur correspond à celle desdits produits; b) des stupéfiants, substances psychotropes, matériels et équipements ou autres instruments utilisés ou destinés à être utilisés de quelque manière que ce soit pour les infractions établies conformément au paragraphe 1 de l'article 3.

[25] OEDT/ELDD, *France Country Profile*, 2001.

proximité d'un établissement d'enseignement, la peine peut être portée à sept ans d'emprisonnement et une amende de 1 000 000 FF (article 227-18). Enfin, le fait de diriger ou d'organiser un groupe engagé dans la production, la fabrication, l'importation et l'exportation, le transport, la détention, la cession, l'acquisition ou l'emploi illicites de stupéfiants peut entraîner une condamnation à perpétuité avec une amende de 50 000 000 FF (article 222-34).

Quelques rapports clés

Le rapport « Pelletier »

Le premier examen de la Loi de 1970 et des politiques françaises en matière de drogues et de toxicomanie a été réalisé en 1978 par une commission présidée par Monique Pelletier, qui a étudié la question à la demande du président Giscard d'Estaing.[26]

Selon le rapport Pelletier, les difficultés de mise en œuvre de la Loi de 1970 résultaient des inégalités de traitement des toxicomanes en raison, partiellement du fait que la loi n'établissait pas de catégorie intermédiaire entre un usager et un trafiquant de drogue. Le rapport attribuait également les problèmes de mise en application au manque de collaboration entre les responsables des questions juridiques et des questions de santé.[27] Les médecins étaient particulièrement sceptiques sur le principe de l'injonction thérapeutique et l'obligation des contrevenants de subir un traitement. Les membres de la Commission Pelletier ont également noté que l'on faisait plus souvent appel aux sanctions pénales qu'aux diverses formes de traitement. Ils ont estimé néanmoins que la Loi de 1970 méritait qu'on lui accorde une deuxième chance, suggérant qu'elle pourrait profiter de la diffusion de lignes directrices claires en matière d'application (circulaires) et de l'apport de ressources structurelles et financières visant à assurer la réussite des options thérapeutiques, sur le plan tant judiciaire que médical. Le rapport proposait, entre autres, que les toxicomanes soient différenciés d'après le type de substance illicite dont ils font usage.[28]

La loi n'établit encore aucune distinction officielle aujourd'hui entre les différentes substances illicites mais, dans la pratique, de nombreuses circulaires ont invité les procureurs et les juges, au cours des 20 dernières années, à distinguer l'usage du cannabis et la consommation d'autres drogues telles que l'héroïne et la cocaïne. Par exemple, selon une circulaire en date du 7 mai 1978, les usagers du cannabis ne devraient pas être considérés comme de « vrais » toxicomanes, les traitements de désintoxication pourraient ne pas convenir à ce type d'usagers et ceux-ci devraient faire

---

[26] Pelletier, M. (1978) *Rapport de la mission d'étude sur l'ensemble des problèmes de la drogue*, Paris : La Documentation française.

[27] Centre d'aide et d'accueil en toxicomanie (CAAT), *La mise en application de la loi.* Voir : http://caat.multimania.com/info/app_loi.htm.

[28] OFDT, 1999, p. 25.

l'objet d'un simple avertissement. On y invitait également les juges à encourager les usagers à communiquer avec un centre pour toxicomanes et à ne recourir à l'injonction thérapeutique qu'à l'égard des récidivistes. La circulaire en question a été perçue par un grand nombre comme une décriminalisation de l'usage du cannabis. Il convient toutefois de faire remarquer que les circulaires expriment les intentions du ministère de la Justice, mais que leur application dépend de la discrétion des procureurs de la République.[29]

La circulaire de 1978 est restée un outil de référence jusqu'au 12 mai 1987, date à laquelle une circulaire conjointe Justice-Santé a abrogé les circulaires précédentes et introduit une nouvelle distinction fondée sur la fréquence d'utilisation.

> *« Toutes les interpellations pour usage doivent faire l'objet d'un procès-verbal transmis au parquet et si possible traité par un magistrat spécialisé. Les usagers « occasionnels », s'ils sont bien insérés, doivent faire l'objet d'un simple avertissement. Pour les usagers « d'habitude », la circulaire recommande le recours à l'injonction thérapeutique ou aux poursuites. Les usagers étrangers, en séjour irrégulier en France, doivent être jugés en comparution immédiate et faire l'objet d'une interdiction de territoire. Enfin, les usagers trafiquants ou usagers délinquants doivent être prioritairement poursuivis du chef d'accusation de trafic ou de l'atteinte aux personnes ou aux biens. Cette circulaire marque également la volonté de relancer l'injonction thérapeutique et en précise les conditions d'application. »*[30]

Cette circulaire a marqué un tournant vers l'adoption de mesures plus répressives pour les consommateurs d'habitude et pour les usagers trafiquants[31] et elle a orienté la politique pénale entre 1990 et 1995 vers la relance de l'injonction thérapeutique et l'établissement d'une distinction entre usager occasionnel, usager d'habitude et usager-revendeur.[32]

Le rapport Trautmann

Le deuxième rapport a été produit en 1989 par Catherine Trautmann, alors présidente de la Mission interministérielle de lutte contre la drogue et la toxicomanie. Déposé en 1990, ce rapport comprenait un examen des données disponibles sur la consommation de drogue et la toxicomanie ainsi qu'une étude des principales difficultés de la lutte antidrogue et des politiques françaises en matière de drogues entre 1978 et 1988.[33]

Aucun changement à la Loi de 1970 n'a été recommandé, le rapport mettant plutôt l'accent sur la nécessité d'intervenir de manière plus efficace contre le trafic des stupéfiants en assurant une meilleure coopération entre les trois services de portée nationale participant à la lutte contre ce trafic (la police, la gendarmerie et les douanes,

---

[29] *Ibid.*

[30] *Ibid.*, page 26

[31] CAAT, 2001, page 3

[32] OFDT, 1999, pages 26 à 27.

[33] Trautmann, C., (1990) *Lutte contre la toxicomanie et le trafic de stupéfiants.* Rapport au Premier ministre. Paris : La Documentation française.

qui ont chacune un champ de compétence particulier : zones urbaines pour la police, zones rurales pour la gendarmerie et régions frontalières pour les douanes) et en renforçant la surveillance de la frontière française. Le rapport suggérait aussi d'insister davantage sur le volet « demande » du problème de la drogue en élaborant des stratégies visant à prévenir l'usage des drogues et la toxicomanie, particulièrement chez les jeunes. Le rapport contenait également des suggestions sur les soins à prodiguer aux toxicomanes, et la question de leur insertion et réinsertion dans la collectivité s'articulait autour de trois axes : améliorer la santé et les services sociaux, tenir compte des problèmes associés au sida et établir un système de gestion financière solide pour appuyer des unités spécialisées offrant des services aux toxicomanes.

Enfin, le rapport Trautmann s'opposait nettement à la décriminalisation ou à la légalisation de l'usage des drogues, en particulier du cannabis. Ses auteurs ont insisté sur la nécessité de prévenir l'usage des drogues et de prendre soin des toxicomanes, et, selon eux, la décriminalisation de l'usage du cannabis banaliserait la toxicomanie et favoriserait la consommation précoce et plus fréquente des drogues dures.[34]

Le rapport Henrion

La Commission Henrion a produit, en 1995, un troisième rapport sur les drogues en France[35] qui en vient aux mêmes conclusions que les deux rapports précédents en ce qui concerne le manque de coordination et de coopération entre les responsables des systèmes judiciaire et sanitaire et les difficultés que pose la mise en œuvre d'une politique fondée à la fois sur des mesures répressives et des mesures d'hygiène publique. La Commission a signalé le recours limité à l'injonction thérapeutique et le nombre croissant d'arrestations pour simple consommation de cannabis. Elle a recommandé avant tout l'élaboration d'une politique d'évaluation permettant de cerner la situation de la drogue en France et a proposé que la politique de la France en matière de drogues mette l'accent sur la prévention. En outre, le rapport a critiqué les incohérences dans l'application de la loi et les inégalités dans le traitement prodigué aux toxicomanes selon les régions, et il a recommandé que les organismes et structures en place chargés de la répression du trafic des stupéfiants soient dotés des ressources financières et humaines leur permettant d'exécuter leur mandat.

Par ailleurs, la Commission Henrion s'est distinguée en proposant une réforme de la Loi de 1970. Sur la question de la décriminalisation du cannabis, ses membres ont exprimé des opinions divergentes, une minorité (8 sur 17) s'y opposant, principalement parce qu'ils pensaient qu'il serait difficile de maintenir l'interdiction morale sans prohibition légale. Une courte majorité de membres (9 sur 17) étaient favorables à la décriminalisation de l'usage et de la possession de petites quantités de cannabis. Ils ont suggéré de procéder graduellement, sans modifier les règles sanctionnant l'offre de cannabis, afin de mieux contrôler et évaluer les conséquences de la décriminalisation de

---

[34] *Ibid.*, Annexe 10, pages 252 et 253.

[35] Henrion, R., (1995) *Rapport de la Commission de réflexion sur la drogue et la toxicomanie.* Rapport au ministère des Affaires sociales, de la Santé et de la Ville. Paris : La Documentation française.

l'usage de cette drogue. Ils ont également recommandé que la décriminalisation soit accompagnée par l'édiction de règles limitant l'usage du cannabis à certains endroits et interdisant sa consommation chez les jeunes de moins de 16 ans. La réglementation réprimerait également l'intoxication dans un lieu public, créerait une infraction de conduite sous l'influence du cannabis et interdirait son usage à certains professionnels pour des raisons de sécurité (notamment les contrôleurs aériens, les pilotes, les conducteurs de véhicules de transport public, etc.). Toutes ces mesures devaient être accompagnées d'une campagne de prévention mettant l'accent sur les conséquences négatives possibles de la consommation de cannabis et d'une évaluation continue portant non seulement sur la consommation de cannabis, mais également sur celle des opiacés, de la cocaïne et du crack, ainsi que sur les recherches neurobiologiques établissant les effets de la consommation du cannabis. Enfin, on maintiendrait et continuerait à appliquer les peines prévues pour l'incitation à la consommation de drogue.[36]

La Commission a laissé entendre que si une telle réforme était retenue et n'entraînait aucune détérioration de la situation au cours des deux années subséquentes, le gouvernement devrait ensuite envisager de réglementer le commerce du cannabis en le plaçant sous le contrôle strict de l'État. Il convient toutefois de noter que certains membres de la Commission étaient persuadés qu'une telle réglementation devait être mise en œuvre parallèlement à la décriminalisation du cannabis et qu'il ne devrait pas y avoir de période d'essai.[37] Ces recommandations n'ont pas eu de suites.

La Commission Henrion a également recommandé l'adoption d'une politique de réduction des méfaits de la drogue qui ne se limiterait pas à réduire les risques de la consommation pour la santé, mais serait axée sur la promotion de la santé publique et réprimerait rigoureusement certains comportements négatifs tels que l'abandon des aiguilles usagées dans un lieu public.[38]

---

[36] *Ibid.*, pages 82-83.

[37] *Ibid.*, page 83.

[38] *Ibid*, page 89.

Rapports d'experts

Nous avons amplement discuté aux chapitres 5, 6 et 7, les données scientifiques de trois récents rapports d'experts, les rapports Roques sur la dangerosité des drogues (1995)[39], Reynaud et Parquet[40] sur les pratiques addictives (1999) et l'expertise collective de l'INSERM[41] (2001) sur le cannabis. Ces divers rapports, qui se complètent et se rejoignent largement sur leurs principales conclusions, constituent, au plan international, une des bases d'information scientifique les plus rigoureuses et surtout les moins idéologiques que nous ayons pu consulter. Il est probable que, n'étant pas associés à une commission chargée d'étudier les aspects des politiques publiques, ces diverses commissions avaient la possibilité d'échapper un peu plus à la contamination possible des interprétations téléologiques des données de recherche.

Statistiques sur l'usage et la répression

Usage

Les données suivantes proviennent du rapport 1999 intitulé *Drogues et toxicomanies : indicateurs et tendances*, préparé par l'Observatoire français des drogues et des toxicomanies.[42]

- Forte diminution des décès causés par les surdoses (554 en 1994, 143 en 1998) ainsi que des décès des sidéens liés à la consommation de drogues injectables (1 037 en 1994, 267 en 1997) ;
- Baisse importante de la consommation d'héroïne depuis 1996, que l'on pourrait attribuer à une augmentation du recours aux traitements de substitution ;
- Normalisation de l'usage du cannabis, dont la consommation est de plus en plus répandue, particulièrement chez les jeunes ;
- Croissance du phénomène que constitue la culture du cannabis ;
- Accessibilité croissante des drogues de synthèse, qui ne représentent toutefois qu'un faible pourcentage des drogues consommées ;
- Augmentation de l'usage de la cocaïne ;
- Nouvelles habitudes de consommation de drogues multiples, y compris les substances licites telles que l'alcool, se manifestant surtout chez les jeunes – 54 % des jeunes pris en charge dans des centres de désintoxication consomment au moins deux produits.

---

[39] Roques, B., (1995) *La dangerosité des drogues.* Paris : Odile Jacob.

[40] Reynaud, M., et coll., (1999) *Les pratiques addictives. Usage, usage nocif et dépendance aux substances psychoactives.* Paris : Secrétariat d'État à la Santé et aux Affaires Sociales.

[41] INSERM (2001) *Cannabis : Quels effets sur le comportement et la santé ?* Paris : auteur.

[42] Observatoire français des drogues et des toxicomanies, *Drogues et toxicomanies : indicateurs et tendances*, Édition de 1999. Disponible en ligne à l'adresse http://www.drogues.gouv.fr/fr/index.html.

Les enquêtes menées en 1995 auprès d'un échantillon représentatif d'adultes français ont révélé que presque 25 % du groupe des personnes âgées de 18 à 44 ans ont fait l'expérience de l'usage du cannabis au moins une fois et que 7,7 % ont déclaré en consommer occasionnellement ou régulièrement. Les enquêtes auprès des appelés dans les centres de sélection du service national en 1996 ont démontré également qu'une large tranche (40 %) des jeunes hommes de 18 à 23 ans avaient fait l'expérience du cannabis et que 14,5 % en avaient consommé au cours du mois écoulé.[43] On estime qu'au cours de la deuxième moitié des années 90, plus d'un tiers des jeunes de 15 à 19 ans ont fait l'expérience de la drogue, particulièrement du cannabis. Ces enquêtes ont également fait état d'une importante augmentation de la fréquence de consommation du cannabis, puisque la proportion des jeunes en ayant consommé au moins dix fois au cours de l'année a augmenté de plus de 50 % entre 1993 et 1997.[44] On a en outre établi que les garçons étaient plus susceptibles que les filles de faire usage de substances illicites et présentaient un risque beaucoup plus élevé d'usage répété. Une étude menée en 1998 a indiqué que 33 % des garçons avaient signalé qu'ils avaient fait l'expérience du cannabis, comparativement à 23 % des filles.[45] Le rapport 2002 de l'OFDT note aussi une augmentation des prises en charge sanitaires ou sociales pour usage de cannabis : environ 15 % des prises en charge seraient pour usage de cannabis. Ces personnes sont généralement plus jeunes que les personnes prises en charge pour usage d'opiacés, plus fréquemment prises en charge pour la première fois, et plus souvent adressées par l'institution judiciaire.[46]

Au cours de la deuxième moitié des années 90, le nombre usagers d'opiacés « à problèmes » (consommation de drogue pouvant entraîner la nécessité d'un traitement prodigué par le système de santé ou le système social ou d'un contact avec les organismes d'application de la loi) se situait dans une fourchette de 142 000 à 176 000 personnes.[47]

Infractions

Le rapport de l'OFDT indique que le nombre d'arrestations pour des infractions en matière de drogue est passé de 45 206 à 90 000 au cours de la période de 1993 à 2000. L'augmentation la plus importante concernait le nombre de personnes arrêtées pour usage de cannabis (79 000 en 2000 comparativement à 30 344 en 1993), alors que le nombre d'arrestations pour consommation d'héroïne était en baisse (14 959 en 1993, 7 469 en 1998 après un sommet de 17 356 en 1995). Le cannabis a motivé 85 % des arrestations en matière de drogues en France en 1998, comparativement à 63 % en 1993. Les personnes interpellées pour usage de cannabis sont les plus jeunes (22 ans en moyenne) des usagers de drogues interpellés. Toutefois, il convient de noter qu'un

---

[43] OFDT, 1999, pages 62 et 63.

[44] *Ibid.*, page 83

[45] *Ibid.*, pages 82 à 84.

[46] OFDT (2002), page 96.

[47] OFDT, 1999, page 64.

peu moins de la moitié des personnes arrêtées pour usage de drogue (45 %) sont placées en garde à vue et que la grande majorité des usagers simples mis en cause (97,2 %) ont été libérés en 1997.[48]

Les études entreprises en France ont insisté sur le fait que les statistiques sur l'arrestation des usagers de drogues doivent être utilisées avec prudence puisqu'il est difficile d'établir la proportion des changements signalés qui reflète les variations de la population des usagers et de savoir combien de ces changements sont plutôt attribuables aux réformes des services de police et de gendarmerie. Par exemple, les données sur les arrestations pour consommation entre 1993 et 1998 ont indiqué une croissance significative de 30 % des arrestations liées à l'usage des drogues en 1997 et de 9% en 1998.[49] De nombreux facteurs peuvent expliquer une telle augmentation, notamment des changements de comportement chez les membres des services de police et de gendarmerie, la réorganisation des départements de police et la « normalisation » de l'usage du cannabis. Parmi ces facteurs, on peut citer une circulaire sur l'injonction thérapeutique diffusée en 1995 par le ministère de la Justice incitant les procureurs à donner des instructions aux membres de la police et de la gendarmerie visant la «systématisation du signalement des usagers ».[50] On peut présumer que de telles directives peuvent avoir contribué à une augmentation notable des arrestations liées à la consommation de drogue enregistrées en 1997.

En ce qui concerne le trafic, le nombre d'arrestations a diminué entre 1996 et 1998, pour passer de 8 412 à 5 541. Un peu plus de la moitié des trafiquants arrêtés en 1998 (52 %) étaient des trafiquants de cannabis, 24 % étaient impliqués dans le trafic de l'héroïne et 17 % dans celui de la cocaïne et du crack. Les principales fluctuations ont été observées dans le nombre d'arrestations des trafiquants d'héroïne, qui est passé de 3 395 en 1993 à 1 356 en 1998. Les arrestations pour trafic de cocaïne sont passées de 383 à 972 au cours de la même période, alors que les arrestations liées au trafic de cannabis ont augmenté légèrement pour passer de 2 456 à 2 920[51]

Le nombre total de condamnations où l'usage est l'infraction principale est passé de 7 434 en 1992 à 6 530 en 1997. En 1997, 3 368 contrevenants ont été condamnés pour usage seul. Parmi ceux-ci, 14 % ont été condamnés à des peines d'emprisonnement d'une durée moyenne de 2,4 mois, 35 % ont reçu une peine avec sursis (souvent associée à la probation et à l'injonction thérapeutique), 33 % se sont vu infliger des amendes, 7% ont eu d'autres sanctions et 6% ont dû s'inscrire à un programme éducatif. Le nombre de condamnations pour usage et transport est passé de 761 en 1991 (6,6 % des condamnations) à 3 478 en 1997 (22,2 %). Les condamnations pour usage et trafic ont également augmenté pour passer de 475

---

[48] *Ibid.*, pages 112 et 113. Il convient de noter que «la remise en liberté recouvre de nombreuses situations et n'implique pas un abandon de poursuite. Certains peuvent être jugés par la suite après convocation au tribunal ».

[49] *Ibid.*, page 112.

[50] *Ibid.*, page 114.

[51] *Ibid.*, pages 164 et 165.

en 1991 à 1501 en 1997 (4,1 % comparativement à 9,6 % des condamnations pour infractions en matière de drogue). Dans 21 % des cas de condamnation pour usage et autres infractions en matière de drogue, une peine de prison a été infligée. Dans 37 % des cas d'usage et de trafic de drogue et 21 % des cas d'usage et de transport de drogue, les personnes condamnées ont écopé de peines mixtes (prison et emprisonnement avec sursis). La durée moyenne d'incarcération était de 16,8 mois en 1997.[52]

En 1998, le nombre de saisies de cannabis a atteint 40 115, comparativement à 27 320 en 1996. Toutefois, les quantités saisies étaient plus modestes en 1998 qu'en 1996 (55 698 kg comparativement à 66 861 kg).

Coûts

En 1995, le budget public consacré à la mise en œuvre de la politique française en matière de drogues était de 4,7 milliards FF. Par rapport aux dépenses totales (budget particulier et crédits interministériels), environ 1 536,56 millions FF ont été dépensés pour la justice, 1260,54 millions FF pour les services de police, 469,55 millions FF pour la gendarmerie et 450,25 millions FF pour les douanes. Le montant dépensé pour l'exécution des lois s'est avéré considérablement plus élevé que les dépenses pour la santé (656,3 millions FF) et les affaires sociales (28,58 millions FF).

Des chiffres plus récents sur les crédits interministériels indiquent que, pour 1998, les dépenses pour la santé et les affaires sociales étaient de 47,9 millions FF, celles consacrées à la justice de 18,9 millions FF, celles du ministère de l'Intérieur (police), 18,5 millions FF et celles de la Défense (gendarmerie), de 10,7 millions FF.

---

[52] OFDT, 1999, p. 121 à 123.

PAYS-BAS[53]

Il s'est dit tout et n'importe quoi sur l'approche néerlandaise en matière de drogues. On nous a dit par exemple :

> *« En Hollande, des études menées au début des années 1990 illustrent l'impact négatif de la tolérance envers les drogues illicites :*
>
> - *Le nombre de boutiques (des « cafés ») qui tirent leurs revenus de la vente de haschisch depuis la dépénalisation de 1990 est passé de 20 à 400 à Amsterdam en 1991 à plus de 2 000 dans toute la Hollande:*
> - *De 1984 à 1988, le nombre de fumeurs de haschisch de plus de 15 ans a doublé en Hollande; de 1988 à 1992, le nombre de fumeurs de 14 à 17 ans a encore doublé, et celui des consommateurs de 12 et 13 ans a triplé;*
> - *Le taux de crimes violents commis en Hollande est le plus élevé d'Europe et il continue de monter. »* [54]

> *« Aux Pays-Bas (il faut être prudent parce que d'énormes différences sociales et culturelles empêchent toute comparaison générale entre le Canada et ce pays), la politique antidrogue visant la réduction des méfaits fait une distinction très nette entre le cannabis et les drogues dites « dures ». Depuis l'adoption de la politique, le cannabis semble moins dangereux et son approbation sociale a augmenté, surtout chez les jeunes dont la consommation de cannabis a quadruplé. La consommation de cannabis dans ce pays, comme dans la plupart des pays du continent européen, s'il faut en croire les statistiques mentionnées, reste inférieure à la consommation au Canada. Mais cela signifie tout simplement que nous devons être encore plus vigilants. La propension à avoir une situation problématique et la probabilité que cela arrive semblent plus élevées au pays. »* [55]

Divers témoins ont cité l'article de Larry Collins publié dans la prestigieuse revue *Foreign Affairs.* Pourtant, cet article est truffé d'erreurs de fait.

Tenant compte du climat qui entoure le débat des politiques sur les drogues, il est difficile de décrire l'approche néerlandaise sans donner l'impression de prendre une position. Rappelons d'abord certains constats que nous avons faits au chapitre 6 et sur lesquels nous reviendrons dans l'analyse comparative au chapitre suivant : d'une part les comparaisons internationales sur les tendances d'usage doivent être faites avec prudence en raison des différences de méthodologie entre les enquêtes ; d'autre part, les

---

[53] Cette section s'inspire notamment du rapport de recherche produit par la Bibliothèque du Parlement à la demande du Comité : Dolin, B., (2001) *Politique nationale en matière de drogues : les Pays-Bas.* Ottawa : Bibliothèque du Parlement. Document produit pour le Comité spécial du Sénat sur les drogues illicites. Disponible en ligne à : www.parl.gc.ca/drogues-illicites.asp

[54] Association canadienne des policiers et policières, Mémoire soumis au Comité spécial du Sénat sur les drogues illicites, 28 mai 2001.

[55] Mémoire du Dr Colin Mangham, *Conséquences de la libéralisation de la politique antidrogue du Canada*, 17 septembre 2001

comparaisons internationales tendent à démontrer que «la relation entre les chiffres mesurant le niveau de consommation du cannabis et modèle législatif en vigueur dans un pays n'est pas évidente ni systématique ».[56]

Comme pour la France, nous commençons par un bref historique de la législation sur les drogues aux Pays-Bas. Nous décrivons ensuite les grandes lignes de sa politique actuelle et de ses outils de mise en œuvre. Nous présentons la législation contemporaine de manière plus précise et les rapports qui l'ont fondée, et fournissons enfin quelques données sur les usages et leur répression.

Le pragmatisme néerlandais ?

Comme les autres puissances coloniales, les Pays-Bas ont entretenu des comptoirs ou régies de production d'opium dans leurs colonies. Ce système permettait des rentrées fiscales significatives : entre 1816 et 1915, on estime que les profits nets tirés de la vente de l'opium représentaient environ 10 % du revenu total des colonies pour le trésor néerlandais. Le pays était aussi le plus important producteur de cocaïne aux fins médicales. Ce n'est qu'à la fin de la Seconde guerre mondiale et l'accession de l'Indonésie à l'indépendance, que les Pays-Bas allaient mettre fin au monopole de l'opium.

> [Traduction] *« Des intérêts économiques bien compris dans la production et le commerce des drogues peuvent expliquer les réserves des Pays-Bas à soutenir le système international de contrôle des drogues. Il est clair que les Pays-Bas ont tenté de protéger leurs intérêts commerciaux lors des conférences, et ont réussi, au moins temporairement, à le faire. (...) Notons au passage que les Pays-Bas se sont aussi opposés à l'inclusion du cannabis dans la convention.. »*[57]

Au cours des années 20 et 30, le pays a été l'objet des critiques de la Ligue des Nations et des États-Unis notamment, pour son important commerce de drogues : parmi les principaux producteurs d'héroïne, il était le principal producteur de cocaïne. Mais les négociateurs néerlandais aux conférences internationales sur les diverses conventions, ainsi qu'une partie de la population elle-même, ne croyaient pas à un système basé sur la prohibition et considéraient déjà, au début du siècle, qu'un système de contrôle gouvernemental serait plus efficace.

C'est cette attitude qui a amené plusieurs analystes à présenter l'approche néerlandaise sur les drogues sous l'angle du pragmatisme.

---

[56] Martineau, H. et É. Gomart (2000) *Politiques et expérimentations sur les drogues aux Pays-Bas.* Rapport de synthèse. Paris : OFDT, page 44.

[57] De Kort, M. (1994) «A short history of drugs in the Netherlands. » in Leuw, E. and I. Haen Marshall (eds.) *Between prohibition and legalization. The Dutch experiment in drug policy.* Amsterdam : Kugler, page 11.

« La société néerlandaise est une société pragmatique. C'est une nation de marchands, et ce, depuis le XVIIe siècle. Or, il n'y a pas plus pragmatique qu'un marchand. Ce pragmatisme néerlandais trouve d'ailleurs sa source dans notre histoire, qui est caractérisée par une lutte constante contre la mer, l'ennemi naturel des Néerlandais depuis le Moyen âge. Les Pays-Bas ont une superficie à peu près comparable à celle de l'Île de Vancouver, et, aujourd'hui, la moitié du territoire de notre pays se situe au niveau de la mer.
Pour protéger notre pays, nous avons érigé un réseau de digues. Il y a des siècles, tous les Néerlandais, depuis les aristocrates jusqu'aux agriculteurs, ont uni leurs efforts pour empêcher la mer d'engloutir leur pays. C'est de là que vient notre pragmatisme. Il est impossible d'enrayer complètement le problème de l'eau. Mieux vaut alors s'en rendre maître en aménageant des canaux. » [58]

Au delà du pragmatisme, d'autres facteurs sont cependant à l'œuvre. Une publication gouvernementale laisse entendre que la nature de la société néerlandaise constitue la raison d'être de son approche :

[Traduction] *« Pour apprécier l'approche néerlandaise du problème des drogues, il faut connaître certaines caractéristiques de la société de ce pays. Les Pays-Bas constituent un des pays urbanisés les plus densément peuplés du monde. Leur population de 15,5 millions d'habitants occupe une superficie de 41 526 km² tout au plus. Les Pays-Bas ont toujours été un pays de transit : Rotterdam est le plus important port de mer du monde et le pays possède un secteur de transport très développé. Les Néerlandais croient fermement à la liberté individuelle et ils attendent de l'État qu'il fasse preuve de réserve dans les questions religieuses ou morales. Le débat libre et ouvert sur de telles questions est l'une des caractéristiques de la société néerlandaise. On attache une grande valeur au bien-être de toute la société, comme en témoignent l'important système de sécurité sociale et l'accessibilité pour tous des soins de santé et de l'enseignement. »* [59]

Il en découle que par tradition les Néerlandais n'ont pas l'habitude de réagir aux problèmes sociaux en se servant du droit criminel.[60] De surcroît, c'est un pays de consensus, où la concertation entre les instances locales, régionales et nationale, ainsi qu'entre les divers secteurs de l'administration publique, a une longue tradition.

Quelles qu'en soient les raisons, l'expérience néerlandaise a fait couler beaucoup d'encre, étonnamment beaucoup plus que l'approche espagnole qui est, à maints égards, encore plus libérale. Appelés à la défendre autant en Europe que dans d'autres forums internationaux, les Néerlandais l'ont souvent présentée comme une position de compromis entre celle des « éperviers » de la lutte contre la drogue et celle des

---

[58] M. Tim Boekhout van Solinge, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 19 novembre 2001, fascicule 11, pages 53-54.
[59] « Drug Policy in the Netherlands », Gouvernement des Pays-Bas, Disponible sur Internet : http://www.netherlands-embassy.org/c_hltdru.html
[60] Boekhout van Solinge, T., (1998) «La Politique de drogue aux Pays-Bas: un essai de changement », *Déviance et Société* Vol. 22, pages 69 à 71.

« colombes » de la légalisation.[61] Il est peu probable qu'il s'agisse là du résultat de facteurs culturels particuliers et que l'expérience néerlandaise ne puisse s'appliquer à d'autres pays. Au contraire, elle semble être plutôt la solution rationnelle apportée par les politiciens à un problème, et on ne peut affirmer qu'il s'agit là d'une caractéristique exclusivement néerlandaise.

Des rapports d'experts fondateurs

Contrairement à la plupart des autres pays où ont été produits, au courant des années 70, des rapports de commissions d'enquête, les Pays-Bas ont été les seuls à mettre en œuvre les recommandations de leur commission.

La Commission Hulsman (1968-1971)

En 1968, la Fédération nationale des organismes de santé mentale[62] a créé une commission dont le mandat général consistait à «clarifier les facteurs associés à l'usage de drogues et à présenter des propositions pour une politique rationnelle ».[63] Présidée par le professeur de droit criminel Louk Hulsman, la Commission était composée de représentants des services policiers et juridiques, de spécialistes du traitement des alcooliques, de psychiatres, d'un chercheur sur l'usage des drogues et d'un sociologue.

Le rapport final de la Commission, présenté en 1971, présentait une analyse de la consommation de drogues et des mécanismes sociaux sous-jacents aux problèmes liés aux drogues. De nouvelles approches ont été suggérées, notamment :

- Supprimer immédiatement du droit criminel l'usage et la possession de petites quantités de cannabis. La production et la distribution devaient alors rester dans le droit criminel, mais comme infractions mineures ;
- L'usage et la possession d'autres drogues devraient demeurer temporairement dans le droit criminel, comme infractions mineures, mais à long terme il faudrait les décriminaliser ; et
- Les personnes ayant des problèmes liés à la consommation de drogue devraient avoir accès à des centres de traitement adéquats.

---

[61] Kaplan, C.D., *et coll.*, « Is Dutch Drug Policy an Example to the World? », in Leuw et Marshall (dir.), *op.cit*.

[62] Aux Pays-Bas, la santé mentale relevait à la fois d'organismes publics et privés organisés en fonction de groupes politiques et de confessions religieuses. La Fédération nationale des organismes de santé mentale était un organisme de coordination.

[63] Louk Hulsman, *Ruimte in het drugbeleid*, Boom Meppel, 1971, page 5, mentionné dans Peter Cohen, « The case of the two Dutch drug policy commissions: An exercise in harm reduction 1968-1976 » (1994, révisé en 1996), Article présenté à la 5e Conférence internationale sur la réduction des méfaits liés aux drogues, 7-11 mars 1994, Fondation de la recherche sur la toxicomanie, Toronto, Disponible en ligne : www.cedro-uva.org/lib/cohen.case.html.

En recommandant la décriminalisation graduelle de toutes les drogues, les auteurs du rapport observaient qu'il est possible d'utiliser les drogues illicites de manière limitée et contrôlée et que la marginalisation des sous-cultures de toxicomanes a des répercussions négatives considérables. Plus précisément, en fréquentant le «milieu de la drogue », un usager de cannabis peut se familiariser avec d'autres drogues et d'autres méthodes de consommation. Bien que la Commission n'ait pas trouvé de preuve de la théorie de l'escalade de l'usage de drogue – qu'on désigne comme «porte d'entrée » dans d'autres contextes – elle admet qu'un type de toxicomanes (p. ex. les utilisateurs d'héroïne) puisse contaminer un autre type de toxicomanes (p. ex. les utilisateurs de cannabis) lorsque les deux types d'usagers se trouvent refoulés dans une sous-culture marginale.

La Commission concluait qu'une fois commencée, la répression policière ne pourrait que s'intensifier constamment pour suivre le rythme d'augmentation de l'usage des drogues. La Commission considérait que la lutte contre l'usage de drogues au moyen du droit criminel laissait à désirer, en plus d'être « extrêmement dangereuse » :

> *« À maintes reprises, le droit criminel a prouvé que les moyens ne correspondent plus aux fins, et les tenants de la répression demanderont une augmentation des mesures de répression, jusqu'à ce qu'elles soient amplifiées de cent fois par rapport à la situation actuelle [...] Cela accentuera la polarisation entre les différentes parties de la société et peut engendrer une violence accrue. »* [64]

Même s'il n'a pas eu d'impact immédiat, le rapport Hulsman a néanmoins influencé le rapport gouvernemental de la commission Baan.

<u>La Commission Baan (1968-1972)</u>[65]

Une commission d'État a été constituée 1968 par le sous-secrétaire à la Santé. Cette commission réunissait certains membres de la Commission Hulsman, des représentants du ministère de la Justice, le chef de la police d'Amsterdam, ainsi que des psychiatres et des sociologues. En 1970, Pieter Baan, l'inspecteur chef de la santé mentale, a assumé la présidence de la Commission, dont le rapport final a été présenté en 1972.

Ce rapport proposait de diviser les drogues selon le risque – acceptable ou inacceptable – qu'elles présentent. Reconnaissant qu'un consensus plus général entre les spécialistes sur la classification des drogues aurait exigé davantage de recherche, le rapport concluait néanmoins que les produits du cannabis étaient relativement bénins et leurs risques pour la santé limités. Même pour les drogues présentant des risques inacceptables, le rapport concluait que le recours au droit criminel n'était pas l'approche qui convient. La Commission proposait, à long terme, la décriminalisation complète, une fois qu'aurait été mis au point un système de traitement efficace. Entre temps, le

---

[64] Dans Cohen, « The case of the two Dutch drug policy commissions »; *op. cit.*, page 3.
[65] *Working Party*, Ministère de la Justice, La Haye, 1972.

système judiciaire devrait servir uniquement d'outil pour amener les toxicomanes endurcis à suivre un traitement.

Parmi les autres conclusions de la Commission Baan, on note :

- Les caractéristiques particulières à la culture des jeunes constituent des déterminants importants de la consommation de drogues et si un comportement soi-disant déviant est stigmatisé par des mesures répressives, la probabilité de l'intensification de ce comportement constitue un danger grave. Ce sera le début d'une spirale qui rendra de plus en plus difficile le retour de l'individu à un style de vie accepté socialement ;
- Chez les jeunes, la consommation de drogue est souvent une expérience de courte durée ;
- La consommation de cannabis ne mène pas à l'usage d'autres drogues, mais comme le signalait le rapport Hulsman, la criminalisation du cannabis favorise le contact entre les usagers du cannabis et les consommateurs de drogues dures ;
- Les usagers de drogues profitent davantage de l'information et de la prévention que de la répression ;
- Le comportement parfois inhabituel des jeunes consommateurs de cannabis découle davantage des normes et des idéologies d'une sous-culture particulière que de la pharmacologie de la substance ; et
- L'usage de cannabis lorsqu'on conduit ou qu'on fait fonctionner des machines dans une usine n'est pas un comportement responsable; il faudrait restreindre la consommation de cannabis aux heures de loisirs afin de limiter les risques pour l'individu ou la société.

Le rapport Baan est aux fondements de ce qui allait devenir le système de tolérance envers le cannabis aux Pays-Bas, dans une préoccupation de santé publique et de séparation des marchés des drogues.

Le rapport Engelsman (1985)[66]

Constatant les limites d'une politique de santé publique essentiellement centrée sur les jeunes (principaux usagers du cannabis) et l'évolution de la consommation d'héroïne, de même que la dégradation de la condition des usagers, le rapport Engelsman va proposer d'étendre aux autres drogues l'approche de tolérance de la Commission Baan. Il va aussi plus loin que le rapport Baan quant à la nécessité de privilégier l'expérience et la parole des usagers dans la définition des politiques, proposant notamment d'exclure les non-usagers du cercle des experts. Pour Engelsman, les usages et les produits ne sont plus les seuls en cause pour expliquer les problèmes des drogues – dures dans ce cas-ci – mais le sont aussi les effets pervers des

[66] Groupe de travail interministériel sur les drogues et l'alcool, (1985) La Haye : Ministère de la Justice.

interventions répressives (soins et police) sur les usagers. Les propositions de politique publique doivent donc éviter de donner suite aux réactions de panique de la société, et viser à intégrer les usagers et normaliser leur usage. L'État doit ici arbitrer entre les usagers et les non-usagers en privilégiant la protection des usagers. Le rapport Engelsman, jugé trop radical dans certains milieux, n'a pas eu de suite.

Rapport « Continuité et Changement » – 1995[67]

En 1995, le gouvernement néerlandais a publié un rapport intitulé *Politique en matière de drogue aux Pays-Bas : Continuité et Changement.* Ce document a été parrainé par le ministre de la Justice, le ministre de la Santé, du Bien-être et du Sport et le secrétaire d'État à l'Intérieur. Ce rapport était dans une certaine mesure la réponse néerlandaise aux pressions internationales (provenant des pays limitrophes ainsi que des États-Unis) ainsi qu'une occasion de préciser dans certains cas et de resserrer dans d'autres cas les règles de tolérance envers le cannabis.

Le rapport rappelle que les Pays-Bas ont toujours adopté une approche pragmatique concernant l'usage de drogue, et que les politiques de prohibition suivies un peu partout dans le monde ont surtout servi à démontrer leurs limites. Dans ce contexte, l'objectif modeste des Pays-Bas est de limiter les problèmes de santé et de société que pose l'usage de drogues dangereuses. C'est cette politique de réduction des méfaits qui a amené le gouvernement néerlandais à distinguer entre les « drogues dures » qui présentent un risque inacceptable pour la santé et les «drogues douces » comme les produits du cannabis, qui ne suscitent pas les mêmes inquiétudes, bien qu'ils soient toujours jugés «à risque ». En ce qui concerne le cannabis, l'hypothèse sous-jacente, toujours valable depuis le rapport de la Commission Baan est que la transition aux drogues dures est davantage attribuable à des facteurs sociaux qu'à des facteurs physiologiques. La séparation des marchés pour permettre aux gens d'acheter des drogues douces dans un milieu où ils ne seront pas exposés à la sous-culture criminelle entourant les drogues dures, permet de créer une sorte de « barrière sociale » qui réduit l'usage de drogues plus dangereuses.

Le rapport examine les effets de la politique néerlandaise en matière de drogues, du traitement de la toxicomanie aux Pays-Bas et des mesures d'application de la *Loi sur l'opium* et souligne notamment que :

- La décriminalisation de la possession de drogues douces pour usage personnel et la tolérance à l'égard des ventes dans des circonstances contrôlées n'ont pas suscité d'augmentation inquiétante de la consommation chez les jeunes. L'ampleur et la nature de la consommation de drogues douces ne diffèrent pas du profil des autres pays de l'Ouest. Pour ce qui est des drogues dures, le nombre de toxicomanes est faible si on le compare au reste de

[67] Ministère des Affaires étrangères (1995) *Continuité et changement.* Le rapport est Disponible sur Internet : www.drugtext.org/reports/wvc/drugnota/0/drugall.htm.

l'Europe et beaucoup plus bas que celui de la France, du Royaume-Uni, de l'Italie, de l'Espagne et de la Suisse ;

- Le nombre de consommateurs d'héroïne de moins de 21 ans a continué de baisser aux Pays-Bas ;
- La consommation de formes moins chères de cocaïne (c.-à-d. le crack) n'a pas fait de percées importantes en Hollande, comme on l'avait craint en raison de la situation aux États-Unis ;
- Le ton du débat public diffère de celui des autres pays parce que l'usage de la drogue n'est plus considéré comme une menace grave à la santé mais plutôt comme une source de nuisances. Les politiques centrées sur la toxicomanie et le traitement ont conduit à une diminution des infections au VIH, et les niveaux continuent de baisser. De même, le taux de mortalité chez les toxicomanes est faible et n'augmente pas, contrairement à ce qui se produit dans les autres pays européens ;
- En ce qui concerne le débat sur la légalisation, le rapport conclut que les inconvénients d'un monopole d'État ou d'un système de permis l'emporteraient sur les avantages pratiques. Le rôle des organisations criminelles serait réduit, mais un système de ce genre imposerait un lourd fardeau sur le plan de la mise en oeuvre et de la surveillance et attirerait probablement davantage les « touristes de la drogue » et les désordres qu'ils causent parfois. De plus, le rapport laisse entendre que ce n'est pas une chose que les Pays-Bas pourraient entreprendre sans les autres pays. Les conventions internationales empêchent la légalisation pure et simple et il faudrait les renégocier ou les dénoncer. Donc, même si seules les drogues douces étaient légalisées aux Pays-Bas, mais pas dans le reste de l'Europe, les organisations criminelles néerlandaises qui exportent les drogues continueraient d'exister et de nécessiter d'importantes activités policières et judiciaires ;
- Les préoccupations étrangères concernant la politique néerlandaise sur les cafés ne portent pas sur l'usage de cannabis dans les établissements, mais sur les touristes de la drogue qui emportent le cannabis dans leur propre pays, une chose particulièrement facile depuis l'abolition des contrôles frontaliers en vertu de l'Accord Schengen. Le rapport confirme le plan gouvernemental visant à réduire la limite d'achat de 30 à 5 grammes pour voir l'effet qu'aura cette mesure sur les exportations illégales[68] ;
- Étant donné le manque de données scientifiques suffisantes, le rapport appuie la recommandation de 1995 du Conseil de la santé néerlandais que soient entrepris des essais médicaux sur l'efficacité de la prescription d'héroïne aux toxicomanes.[69]

---

[68] Comme on le mentionne dans la section sur la législation actuelle, cette limite réduite est maintenant en vigueur.

[69] Comme on le mentionne dans la section sur la législation actuelle, les essais ont commencé en 1998.

Le rapport fait également état de trois conséquences négatives qu'il faut corriger : les troubles causés par les usagers de drogues dures et douces ; la présence de plus en plus grande du crime organisé aux Pays-Bas ; et l'effet de la politique néerlandaise sur les autres pays.

- Les nuisances d'ordre criminel et général causées par les usagers de drogues dures néerlandais et étrangers ont parfois pour effet d'éroder l'appui du public à l'égard de la politique d'intégration sociale des toxicomanes. Quelques usagers de drogues dures commettent un grand nombre de délits contre les biens pour acheter leur drogue. Contrairement aux attentes, le fait que la méthadone soit plus facile à obtenir a peu amélioré la situation. Les crimes liés à la drogue et le comportement antisocial, tels que le fait de jeter les aiguilles usagées sur les places publiques, ont influé sur les niveaux de tolérance des résidants de certains quartiers défavorisés socialement dans les grandes villes néerlandaises. Les nuisances attribuables à la présence de cafés vendant de la drogue constituent également un problème dans certaines municipalités.[70]
- La montée des organisations criminelles impliquées dans l'offre et la vente de drogues aux Pays-Bas constitue une autre complication qui a nécessité l'augmentation des mesures de droit criminel. La poursuite des trafiquants de drogues demeurera une priorité absolue pour la police et les autorités judiciaires néerlandaises.
- Bien que la « nature idéologique » de certaines critiques étrangères révèle un manque de compréhension de la politique néerlandaise et soit souvent fondée sur de prétendus risques pour la santé qui ne sont pas confirmés dans la littérature scientifique, certains problèmes des Pays-Bas ont des répercussions internationales. Les Néerlandais, par exemple, sont responsables de plus que leur part proportionnelle du trafic des drogues douces et les touristes de la drogue achètent régulièrement des drogues douces aux Pays-Bas avec l'intention de les emporter dans leur pays. Le rapport laisse entendre que pour lutter contre ces problèmes, il faudra poursuivre et augmenter les activités d'application de la loi qui visent avant tout le trafic.

On peut ainsi caractériser l'approche néerlandaise suivie depuis 1976 par trois grands principes :

- Réduction des méfaits : atténuation des risques et des dangers liés à l'usage de drogues plutôt que l'interdiction de toutes les drogues dont les éléments clés sont :

[70] À la suite du rapport, les mesures contenues dans le « projet de loi Damoclès » de 1999 (dont il estquestion dans le présent document) visaient à résoudre le problème en donnant aux municipalités plus de pouvoirs pour fermer les cafés qui sont une nuisance locale.

- La prévention et l'atténuation des risques sociaux et individuels découlant de l'usage de drogue ;
- Un rapport rationnel entre ces risques et les politiques ;
- Une différenciation des politiques selon les risques associés aux drogues ;
- La priorité aux mesures de répression contre le trafic de drogues ; et
- L'inefficacité du droit criminel en ce qui concerne les aspects autres que le trafic du problème de la drogue.[71]

- Politique de « normalisation » : le contrôle social est exercé au moyen de la dépolarisation et de l'intégration du comportement déviant plutôt que par l'isolement et le retrait, typiques du modèle dissuasif. Selon ce paradigme, il faut considérer les problèmes de drogues comme des problèmes sociaux normaux plutôt que comme des problèmes inhabituels exigeant un traitement extraordinaire.
- La séparation des marchés : en classant les drogues selon les risques connus et en appliquant des politiques qui servent à isoler chaque marché, on croit que les usagers de drogues douces seront moins susceptibles d'entrer en contact avec les usagers de drogues dures. Selon cette théorie, les usagers de drogues douces seront moins susceptibles d'essayer les drogues dures.

La législation

C'est en 1919 que les Pays-Bas ont adopté la première loi sur l'opium sous l'influence des conventions internationales, dont celle de La Haye en 1912. Cette législation prohibe la fabrication, la vente, le traitement, le transport, la fourniture, l'importation, l'exportation et la détention de la cocaïne, de l'opium et de ses dérivés. La loi est modifiée en 1928 pour inclure les dérivés de la cocaïne et le cannabis dans la liste des substances contrôlées. Toutefois, seuls les faits d'importation, d'exportation et de transfert de ces substances sont prohibés. Les délits de possession et de fabrication du cannabis et de ses dérivés ne seront punissables qu'à compter de 1953.

La *Loi sur l'opium* – également connue sous le nom de *Loi sur les narcotiques* – constitue la principale loi sur les drogues des Pays-Bas. La *Loi* criminalise la possession, la culture, le trafic ainsi que l'importation et l'exportation de drogues. Les modifications de 1976 définissent deux catégories de drogues : les drogues de l'annexe I présentent un risque inacceptable pour la société néerlandaise et comprennent l'héroïne, la cocaïne, les amphétamines et le LSD et les drogues de l'annexe II

---

[71] Grapendaal, M., Leuw, E., et H. Nelen, (1995) *A World of Opportunities: Life-Style and Economic Behaviour of Heroin Addicts in Amsterdam*, New York, S.U.N.Y. Press, mentionné dans Boekhout van Solinge, T., (1999) « Dutch Drug Policy in a European Context », *Journal of Drug Issues* Vol 29, No 3, 511, disponible sur Internet : www.cedro-uva.org/lib/boekhout.dutch.html.

comprennent les « produits du chanvre traditionnels » tels que la marijuana et le hachisch.

Les délits

La loi se caractérise par trois aspects :

- L'incrimination de la possession, du commerce, de la culture, du transport, de la fabrication, de l'importation et de l'exportation des stupéfiants, **y compris du cannabis et de ses dérivés** ;
- Une distinction nette entre les fournisseurs et les consommateurs; la loi punit la possession pour usage, non l'usage proprement dit ;
- Des sanctions appareillées selon les substances mises en cause.

La possession d'une des drogues désignées dans les deux annexes constitue un délit, mais la possession d'une petite quantité de drogue « douce » pour usage personnel est une infraction mineure. Habituellement, elle est tolérée par la police, en particulier dans le réseau de cafés réglementés dont il est question dans la section suivante. L'importation et l'exportation constituent les infractions les plus graves selon la *Loi*.

Les peines

La peine maximale pour l'importation ou l'exportation de drogues dures est une période de 12 ans de détention et une amende de 100 000 florins.[72] Quiconque est trouvé en possession d'une quantité de drogue dure pour usage personnel est passible d'une peine de un an de détention et d'une amende de 10 000 florins. L'importation ou l'exportation de drogues douces peuvent entraîner une peine maximale de quatre ans de détention et une amende de 100 000 florins. Les récidivistes sont passibles d'une peine maximale de 16 ans de détention et d'une amende de un million de florins. De plus, les contrevenants peuvent être privés de l'argent ou des biens obtenus par leur méfait. Les Pays-Bas ont également des lignes directrices pour les peines que le procureur de la Reine est autorisé à demander ; elles sont basées sur le type et la quantité de drogue et le délit particulier. Les tableaux suivants résument les lignes directrices actuelles (1996).[73]

---

[72] 100 000 florins néerlandais = environ 63 000 $CAN

[73] Source : Staatscourant (1996) in Korf D.J. et H. Riper, (1999) «Windmills in their Minds? Drug Policy and Drug Research in the Netherlands », *Journal of Drug Issues* Vol 29, No 3, 451, au tableau 2.

SUBSTANCES DE L'ANNEXE I (« DROGUES DURES »)		
Délit	**Quantité**	**Peine à réclamer[74]**
Possession	< 0,5 g ou < 1 unité de consommation	Avis de la police (« Police Dismissal »)
	0,5-5 g ou 1-10 unités de consommation	1 semaine - 2 mois
Possession et indication de vente (« Dealer Indication ») (c.-à-d. intention de vendre)	< 15 g ou < 30 unités de consommation	Jusqu'à 6 mois
	15-300 g ou 30-600 unités de consommation	6-18 mois
	> 300 g ou > 600 unités de consommation	18 mois - 4 ans
Commerce dans la rue ou à domicile	< 1 g	Jusqu'à 6 mois
	1-3 g	6-18 mois
	> 3 g	18 mois - 4 ans
Commerce de niveau intermédiaire	< 1 kg	1-2 ans
	> 1 kg	2+ ans
Commerce de gros	> 5 kg	6-8 ans
Importation et exportation	< 1 kg	Jusqu'à 3 ans
	> 1 kg	3-12 ans

ANNEXE II (« DROGUES DOUCES »)		
Délit	**Quantité**	**Peine à réclamer[75]**
Possession, préparation, transformation, vente, livraison, approvisionnement, transport et fabrication	Jusqu'à 5 g	Avis de la police (« Police Dismissal »)
	5-30 g	Amende de 50-150 florins
	30 g-1 kg	Amende de 5-10 florins par g
	1-5 kg[76]	Amende de 5 000-10 000 florins et 2 semaines par kg

[74] En plus de l'emprisonnement, il y a parfois des amendes et la saisie de biens (sauf pour possession).

[75] En cas de récidive dans les cinq ans, la peine requise est augmentée du quart. Pour ce qui est des ventes à des «groupes vulnérables » (c.-à-d. mineurs, patients en psychiatrie), il y a aussi une amende minimale d'environ 475 $CAN.

[76] Les quantités supérieures à 1 kg sont considérées comme dénotant le commerce de drogue.

ANNEXE II (« DROGUES DOUCES »)		
Délit	Quantité	Peine à réclamer[75]
	5-25 kg	Amende max. de 25 000 florins et 3-6 mois
	25-100 kg	Amende max. de 25 000 florins et 6-12 mois
	> 100 kg	Amende max. de 25 000 florins et 1-2 ans
Culture	Jusqu'à 5 plants	Avis de la police
	5-10 plants	50 florins par plant (récidiviste : 75 florins par plant)
	10-100 plants	25 florins par plant et/ou ½ journée par plant
	100-1 000 plants	Amende max. de 25 000 florins et 2-6 mois
	>1 000 plants	Amende max. de 25 000 florins et 6 mois – 2 ans
Importation et exportation	La *Loi* ne fait pas de distinction entre les quantités, mais en pratique l'accusation recommande une peine correspondant aux divisions de quantité pour possession.	Les peines pour possession sont parfois doublées à un maximum de 4 ans et une amende de 100 000 florins.

***Le régime des* coffee shops**

Contrairement à plusieurs stéréotypes, la possession de cannabis n'est pas décriminalisée ; elle constitue toujours, *stricto sensu*, une infraction pénale. Par contre, en vertu du principe d'opportunité des poursuites qui fait partie de la tradition de droit pénal aux Pays-Bas, la possession de petites quantités de cannabis pour usage personnel n'est pas incriminée. De même, la vente de cannabis est techniquement une infraction au sens de la *Loi sur l'opium*, mais les lignes directrices de mise en accusation prévoient que les poursuites seront intentées seulement dans certaines situations.

Sans légaliser la vente de cannabis et de ses dérivés, les municipalités peuvent permettre la création de *coffee shops* qui, sous certaines conditions, sont autorisés à vendre du cannabis. L'exploitant ou le propriétaire d'un café (sans permis d'alcool) évitera la mise en accusation s'il se conforme aux critères suivants :

- Ne pas vendre plus de 5 grammes à la fois à une même personne ;
- Ne pas vendre de drogues dures ;
- Ne pas faire de réclame pour les drogues;

- Ne pas occasionner de nuisance pour le voisinage du café ;
- Ne pas vendre de drogues aux mineurs (moins de 18 ans) et ne pas accepter de mineurs dans l'établissement ;
- La municipalité n'a pas ordonné la fermeture de l'établissement.

[Traduction] *« L'idée de base derrière le système des coffee shops néerlandais est la réduction des méfaits. Dans cette perspective, si nous ne poursuivons pas l'usage et la vente de petites quantités dans certaines conditions, les usagers – principalement des jeunes qui expérimentent l'usage de drogues – ne sont pas criminalisés (ils n'ont pas de dossier judiciaire) et ils ne sont pas forcés de fréquenter des milieux criminels où les risques d'être amenés à consommer des drogues plus dangereuses comme l'héroïne sont beaucoup plus grands. »* [77]

Il est courant pour les municipalités d'avoir une politique sur les cafés afin de prévenir ou combattre les nuisances parfois associées à ces établissements. À titre d'exemple, le soupçon de vente de drogues dures ou l'installation d'un café près d'une école ou dans un quartier résidentiel peut entraîner la fermeture. En avril 1999, la « loi Damoclès » a modifié la *Loi sur les narcotiques* en élargissant les pouvoirs municipaux à l'égard des cafés et en permettant aux maires de fermer les établissements de ce genre qui enfreignent les règlements locaux, même s'ils ne causent aucune nuisance. Par suite de l'application rigoureuse de la loi et de diverses mesures administratives et judiciaires, le nombre de cafés a diminué considérablement, passant de 1 200 en 1995, à 846 en novembre 1999.[78]

On observe ainsi trois sortes de politiques sur les *coffee shops* :

- Tolérance sans condition quant au nombre de coffee shops, dont le nombre est décidé par les mécanismes du marché ; cette situation est la plus rare ;
- Tolérance conditionnelle, fixant un maximum de *coffee shops* ;
- Tolérance zéro : aucun *coffee shop*; c'est le cas d'environ 50 % des villes.

Pour déterminer le nombre idéal de *coffee shops*, l'association des municipalités recommande de tenir compte de facteurs démographiques (nombre d'habitants, tranches d'âge) et d'urbanisation (rôle de la ville par rapport à la région; nombre de centres dans la ville), ainsi que des nuisances causées par l'usage de drogues douces.

« Ainsi, dans la plupart des municipalités, les coffee shops ne sont-ils acceptés que dans le centre-ville, à un nombre fixe maximum et suivant des critères de distance – distance des établissements entre eux et distance entre les coffee shops et certaines institutions comme les écoles ou les hôpitaux psychiatriques.

---

[77] Dr Robert Keizer, *The Netherland's Drug Policy*. Mémoire soumis au Comité spécial du Sénat sur les drogues illicites, 19 novembre 2001.

[78] National Drug Monitor, « Fact Sheet: Cannabis Policy, Update 2000 », Institut Trimbos, 2000.

(...) Les difficultés rencontrées par certains maires face au juge administratif sont provenues de l'absence de plaintes ou de procès-verbaux considérée par certains magistrats comme une absence de preuves de nuisances concrètes (...). Une politique « bien motivée » est finalement une politique qui s'appuie sur une procédure de consultation des experts en toxicomanie et en santé publique, de la police et, dans certains cas, de la population elle-même (usagers inclus). C'est aussi une politique équilibrée dans le sens où elle prend en compte les intérêts non seulement des citoyens « moyens » irrités par les nuisances, mais ceux des consommateurs de drogues douces. » [79]

Depuis la note sur les nuisances publiques de 1993 et le resserrement des conditions de délivrance des permis en 1999, les autorités municipales peuvent en fait délivrer des «permis de nuisance » qui servent ainsi à contrôler le nombre de coffee shops, sans par ailleurs contrevenir aux orientations fondamentales du système néerlandais.

Données sur l'usage

Malgré le «pragmatisme » néerlandais, il existe somme toute peu de données quantitatives fiables sur les tendances d'usage, sur une base historique. On ne peut donc affirmer que les tendances d'usage auraient augmenté significativement après l'introduction du système des *coffee shops*, mais ni non plus qu'elles auraient diminué. La création de l'Institut Trimbos et sa désignation comme point focal du réseau européen de l'OEDT sont en train de corriger cette situation.

Les tableaux suivants présentent quelques données issues des enquêtes les plus fiables.

USAGE DU CANNABIS AUX PAYS-BAS CHEZ LES PERSONNES ÂGÉES DE 12 ANS ET PLUS - 1997

En ont déjà utilisé	16 %
En ont utilisé au cours du dernier mois	2,5 %
En ont utilisé pour la première fois au cours de l'année écoulée	1 %
Âge moyen des usagers courants	28 ans

[79] Martineau et Gomart, *op. cit.*, page 85, pour la citation et pour les informations qui précèdent aussi.

USAGE DU CANNABIS DANS LES QUATRE GRANDES VILLES ET DES PETITES VILLES, PERSONNES ÂGÉES DE 12 ANS ET PLUS - 1997

	Déjà utilisé	Usage récent
Amsterdam	37 %	8 %
Utrecht	27 %	4 %
La Haye	20 %	4 %
Rotterdam	19 %	3 %
Petites villes[a)]	11 %	

A) Définition : Villes comptant moins de 500 adresses au kilomètre carré.

USAGE DU CANNABIS CHEZ LES 16 ANS ET PLUS DANS TROIS ZONES URBAINES. ANNÉE DE L'ENQUÊTE – 1999

	Déjà utilisé[a)]	Usage récent[b)]
Utrecht	30 %	7 %
Rotterdam	19 %	6 %
Parkstad Limbourg	13 %	5 %

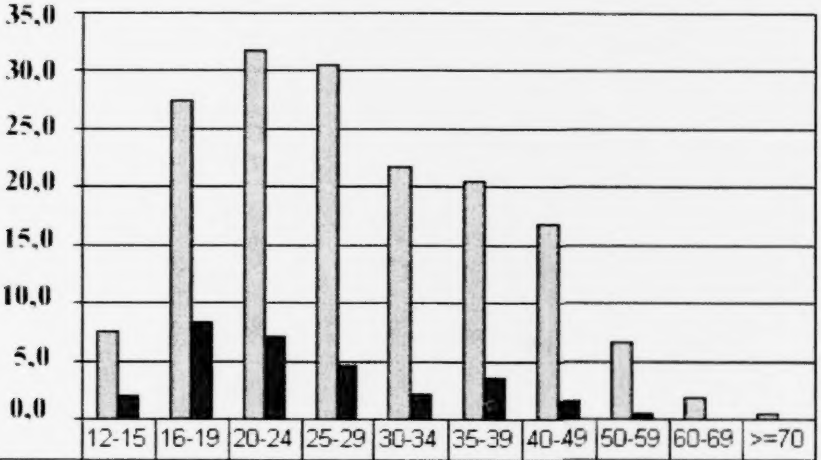
Pourcentage des usagers : [a)] 16 à 70 ans, [b)] 16 à 55 ans. Usage récent : le mois précédent

CONSOMMATION DE CANNABIS AUX PAYS-BAS – USAGERS RÉCENTS DE 12 ANS ET PLUS - 1997

Jours d'utilisation au cours du mois précédent	Pourcentage chez les usagers récents[a)]
1-4	45 %
5-8	14 %
9-20	15 %
Plus de 20 jours	26 %

[a)] Le total des quatre groupes s'élève à 100 p. 100.

USAGERS DU CANNABIS AUX PAYS-BAS PAR GROUPE D'ÂGE. ANNÉE DE L'ENQUÊTE – 1997



	12-15	16-19	20-24	25-29	30-34	35-39	40-49	50-59	60-69	>=70
deja utilisé	7,5	27,5	31,7	30,6	21,7	20,5	16,8	6,7	1,9	0,5
usage récent	2,0	8,3	7,1	4,7	2,1	3,6	1,5	0,5	0,0	0,0

OÙ LES JEUNES SE PROCURENT-ILS LEUR CANNABIS?

	1996	1999
Obtiennent le cannabis de leurs amis	41 %	47 %
Achètent le cannabis dans les cafés	41 %	32 %
Achètent le cannabis d'un vendeur	11 %	11 %
Reçoivent du cannabis des autres	5 %	8 %
Achètent le cannabis à l'école	3 %	1 %
Le cultivent eux-mêmes[a)]	-	2 %

Élèves âgés de douze ans et plus dans les écoles secondaires (usagers récents).
[a)] Évalué seulement en 1999.

USAGE RÉCENT DE CANNABIS DANS LES GROUPES SPÉCIAUX

Jeunes des groupes suivants :	*Année de l'enquête*	*Âge*	*Usage récent*
Écoles secondaires spécialisées	1997	12-18	14 %
Projets d'absentéisme	1997	12-18	35 %
Établissements judiciaires	1995	-	53 %
Établissements de soins pour les jeunes	1996	10-19	55 %
Jeunes itinérants	1999	15-22	76 %

Nous avons déjà vu au chapitre 6 que les données disponibles sur les Pays-Bas placent ce pays quelque part au milieu du peloton, derrière l'Australie, les États-Unis, le Royaume-Uni, l'Espagne et le Danemark, et loin devant la Suède ou la Finlande.

Quoiqu'il en soit, et malgré les annonces de désastre que certains analystes ont parfois pu lancer, l'expérience néerlandaise ne pose pas tant des problèmes reliés à l'usage dans sa population qu'elle n'a présenté des difficultés internes relatives aux nuisances occasionnées par les *coffee shops* pour les citadins et pays voisins, Allemagne, France et Belgique, en raison du narco-tourisme. Plus significatif encore, le système néerlandais tout en demi-mesures, est confronté au problème de l'approvisionnement des *coffee shops* en cannabis et produits dérivés qui demeure, lui, dans l'illégalité parfaite.

> *« La Hollande n'échappe pas plus que les autres pays aux critiques. D'un point de vue théorique, c'est le principe même d'une légalisation de facto qui est discutable. Elle favorise l'arbitraire et surtout laisse le champ libre au trafic. Autant la légalisation de l'usage a permis d'appréhender au mieux le phénomène, de le rendre visible pour mieux le traiter, autant celle du trafic empêche tout contrôle. (...) Sur le plan pratique, les critiques sont tout aussi fondamentales. La principale est que la politique hollandaise n'a pas réduit l'usage de drogues, dures ou douces. (...) La politique néerlandaise n'a pas non plus supprimé les risques liés à l'abus de drogues. (...) Mais on doit aussi reconnaître, et porter au crédit de la politique hollandaise que, si elle n'a pas vraiment fait mieux que les pays prohibitionnistes dans la lutte contre l'usage, elle n'a pas fait pire. »*[80]

Et le plus remarquable, somme toute, c'est la capacité des intervenants néerlandais eux-mêmes, comme en font foi leurs témoignages devant notre Comité, à reconnaître les faiblesses et les erreurs de leur approche, cherchant constamment des moyens de les corriger.

[80] Caballero et Bisiou (2000), *op. cit.*, pages 770-772.

ROYAUME-UNI[81]

Stratégie décennale de lutte contre la toxicomanie

En 1998, au même moment où le gouvernement travailliste nouvellement élu annonçait un imposant programme de réduction de la criminalité, il adoptait, sur un modèle similaire, une stratégie décennale destinée à combattre l'usage abusif des drogues au RU.[82] La stratégie comporte quatre objectifs :

- Aider les jeunes à résister à l'usage abusif de drogue, afin de leur permettre d'atteindre leur plein potentiel et, pour ce faire, réduire le nombre de jeunes de 25 ans et moins qui déclarent avoir utilisé des drogues illicites au cours du mois passé ou de l'année précédente. Le programme mise sur l'éducation dans les écoles et la prévention auprès des jeunes à risque.
- Réduire la récidive chez les contrevenants toxicomanes en leur donnant la possibilité de suivre un traitement approprié. Pour ce faire, diverses options de traitement ont été ajoutées aux étapes de l'arrestation, de la procédure de probation et de la comparution devant les tribunaux. De plus, de nouvelles ordonnances de traitement et de dépistage de la toxicomanie seront à la disposition de tous les tribunaux de l'Angleterre et du pays de Galles. Le juge pourra, avec le consentement du contrevenant, rendre une ordonnance obligeant celui-ci à suivre un traitement parallèlement à l'exécution de services communautaires, ou comme peine en soi. En outre, le programme connu sous le nom de *Carats* (*Counselling, Assessment, Referral, Advice and Throughcare* ou « counselling, évaluation, renvoi, conseils et soins complets ») est offert dans toutes les prisons de l'Angleterre et du pays de Galles, et d'autres programmes de réhabilitation en milieu carcéral sont prévus.
- Reconnaissant que le temps d'attente constitue un des principaux problèmes pour les personnes qui ont besoin d'un traitement et que l'offre de services de traitement est bien inférieure à la demande, le plan gouvernemental prévoit la création d'un organisme national (*National Treatment Agency*) qui sera chargé de fournir les traitements et de veiller à la prestation de services de haute qualité. Les stratégies de réduction des méfaits seront aussi augmentées.
- Réduire l'accès aux drogues chez les jeunes de 5 à 16 ans, augmenter les saisies de drogues de catégorie A, neutraliser un plus grand nombre de trafiquants de catégorie A et augmenter les saisies de biens des trafiquants.

---

[81] Cette section s'inspire notamment du rapport d'étude préparé pour le Comité par la Bibliothèque du Parlement : Lafrenière G., (2001) *Politique nationale en matière de drogue : le Royaume-Uni.* Ottawa : Bibliothèque du Parlement, préparé pour le Comité spécial du Sénat sur les drogues illicites ; Disponible en ligne à www.parl.gc.ca/drogues-illicites.asp

[82] *Tackling Drugs to Build a Better Britain.*

Des objectifs ambitieux ont été fixés dans le premier rapport annuel du coordonnateur antidrogue, notamment :

- Réduire de moitié le nombre de jeunes qui consomment des drogues illicites (notamment l'héroïne et la cocaïne) ;
- Réduire de moitié les niveaux de récidive chez les contrevenants toxicomanes ;
- Doubler le nombre de toxicomanes en traitement ; et
- Réduire de moitié la disponibilité des drogues dans la rue (notamment l'héroïne et la cocaïne).

Bien que la stratégie décennale soit axée sur les drogues les plus nocives (héroïne et cocaïne), plus de 100 000 personnes par année[83] se voient imposer des sanctions pour possession de cannabis, variant de l'amende, à l'avertissement et dans certains cas à la peine de prison.

Cadre législatif

La principale loi sur les drogues illicites au RU est la *Misuse of Drugs Act 1971* (*MDA*) (qui est l'équivalent de la *Loi réglementant certaines drogues et autres substances* du Canada). La loi et ses règlements (*Misuse of Drugs Regulations 1985*) régissent l'usage des drogues énumérées (comprenant les médicaments et les drogues à usage non médical). Ils stipulent les circonstances dans lesquelles il est légal d'importer, de produire, d'offrir, de posséder dans le but d'offrir et d'avoir en sa possession des drogues désignées.

Dans l'annexe 2 de cette Loi, les drogues sont classées en catégorie A, B ou C, pour indiquer leur degré présumé de nocivité. Des peines maximales différentes sont prévues pour chaque catégorie et s'appliquent aux infractions concernant les drogues.

- La *catégorie A* est réservée aux drogues « les plus nocives » auxquelles s'appliquent les sanctions les plus sévères. Cette catégorie comprend entre autres, l'héroïne, la morphine, la méthadone, la cocaïne, l'opium, ainsi que les hallucinogènes tels que l'ecstasy et le LSD. Elle comprend également le cannabis liquide (huile de hachisch), le cannabinol et les dérivés de cannabinol, ainsi que toutes les drogues de catégorie B préparées pour injection.
- La *catégorie B* comprend le cannabis, la résine de cannabis, les opioïdes moins puissants (codéine), les stimulants synthétiques (amphétamines orales) et les sédatifs puissants (barbituriques).
- La *catégorie C* est réservée aux drogues qui sont considérées moins nocives telles que les tranquillisants, certains stimulants moins puissants et les analgésiques opioïdes légers.

---

[83] « Drug Laws: the debate nobody wants », *The Guardian*, le 14 mai 2001.

Le *Home Secretary* (secrétaire de l'Intérieur) peut changer la classification des drogues au moyen d'une législation déléguée, ce qui vient d'être fait pour le cannabis, déclassé à la catégorie C. Cette modification signifie que la possession de cannabis aux fins personnelles ne fera plus l'objet de poursuites pénales mais seulement d'un avertissement policier.

Les articles 3 à 6 décrivent les activités interdites en ce qui concerne les drogues. Ces activités incluent l'importation et l'exportation (les infractions et la procédure de mise en accusation sont décrites dans la *Customs and Excise Management Act 1979*), la production, l'offre, la possession et la possession avec intention d'offrir. La culture du cannabis constitue une infraction séparée, mais elle fait aussi partie de la production. En vertu de l'article 8, il est interdit à l'occupant de permettre sciemment l'utilisation de ses locaux pour la production, le stockage de n'importe quelle drogue désignée, la préparation d'opium pour fumer, ou pour fumer du cannabis, de la résine de cannabis ou de l'opium préparé. L'article 9 contient une série d'infractions liées à l'opium, notamment fumer ou utiliser l'opium autrement. L'article 9A interdit d'offrir tout article qui peut servir à l'administration illégale de drogues (les seringues hypodermiques sont exclues de cette interdiction pour les besoins des programmes d'échange de seringues). Les articles 18 à 21 décrivent d'autres infractions, traitant principalement de l'incitation à enfreindre la *MDA*.

Les sanctions et les peines sont décrites dans les articles 25 et 26. L'article 27 traite de confiscation (forfeiture).

- Pour les drogues de catégorie A, les peines maximales sont les suivantes : sept ans et/ou une amende illimitée pour possession; prison à vie et/ou amende illimitée pour production ou trafic et une peine obligatoire de sept ans en cas de troisième condamnation pour trafic. La peine obligatoire en cas d'une troisième condamnation pour trafic est prévue dans la *Criminal Sentences Act 1997*.
- Pour les drogues de catégorie B, les peines maximales sont : cinq ans et/ou amende illimitée pour possession; et quatorze ans et/ou une amende illimitée pour production ou trafic.
- Pour les drogues de catégorie C, les peines maximales sont : deux ans et/ou une amende illimitée pour possession; et cinq ans et/ou amende illimitée pour trafic.

De plus, les producteurs et les trafiquants sont susceptibles de voir leurs biens confisqués en vertu de la *Drug Trafficking Act 1994*. Tel que mentionné précédemment, la culture de cannabis peut donner lieu à des poursuites en vertu de l'article 4 (production) de la *MDA* plutôt qu'en vertu de l'article 6 (culture), distinction importante puisque la production est considérée comme un délit de trafic aux fins de la *Drug Trafficking Act 1994*. En 1997, 4168 personnes ont été accusées de délits de production dont 92 % touchaient la production de cannabis (25 % de ces contrevenants ont reçu un avertissement et 18 % de ceux qui ont été trouvés coupables

ont été condamnés à la détention immédiate). Parmi les délits de trafic au sens de la *Drug Trafficking Act 1994*, se trouvent la production, l'offre et la possession avec intention de vendre, ainsi que les délits d'importation en vertu de la *Customs and Excise Management Act 1979*.

Au RU, la plupart des infractions en matière de drogues se règlent par un jugement sommaire rendu par un magistrat ou un procès devant jury à la *Crown Court* (cour criminelle). Si le jugement est sommaire, la peine maximale ne peut excéder six mois et/ou une amende de 5000 £, ou trois mois et/ou une amende pour les délits moins graves.

L'article 7 permet de faire des règlements pour exempter certaines activités des dispositions concernant les infractions, permettant ainsi l'utilisation des drogues pour la médecine et la recherche scientifique. La *Misuse of Drugs Regulations 1985* divise les drogues en cinq annexes. Les règlements décrivent les catégories de personnes autorisées à manipuler les drogues désignées dans le cadre de leurs activités professionnelles et stipulent les conditions dans lesquelles certaines activités peuvent être poursuivies. Des règles plus sévères s'appliquent aux drogues de l'annexe 1 concernant l'importation, l'exportation, la production, l'offre, la possession, la préparation d'ordonnances et la tenue des registres ; on observe un relâchement graduel des règles pour les autres annexes. Par exemple, les drogues les plus restreintes de l'annexe 1 (comme le LSD et le cannabis) peuvent être possédées ou fournies seulement pour la recherche ou une autre fin particulière et seulement à des personnes autorisées ; ces drogues ne sont pas disponibles pour les usages thérapeutiques normaux et ne peuvent être prescrites par les médecins n'ayant pas de permis à cet effet. Les drogues de l'annexe 2 – fournies sur ordonnance seulement – font l'objet de plusieurs contrôles relatifs aux ordonnances, à l'entreposage sécuritaire et au besoin de tenir des registres. Par ailleurs, les drogues de l'annexe 5 sont soumises à un minimum de contrôles administratifs et peuvent être importées, exportées et possédées pour usage personnel.

Le cannabis, les cannabinoïdes psychotropes et les produits dérivés sont classés dans l'annexe 1 comme n'ayant pas d'effet thérapeutique. En conséquence, ils ne peuvent être prescrits et possédés qu'à des fins de recherche par une personne autorisée. Le Nabilone (un cannabinoïde synthétique) peut être prescrit aux patients qui souffrent de nausées et de vomissements dus au traitement du cancer par la chimiothérapie et qui sont réfractaires aux autres médicaments. Le Dronabinol (un cannabinoïde) a été rayé de l'annexe 1 pour être inscrit à l'annexe 2 et on peut le prescrire. Cependant, il n'est toujours pas autorisé au RU et doit être prescrit à un « patient désigné nommément ».

L'article 10 permet d'établir des règlements sur la garde en lieu sûr, la documentation des transactions, la tenue des registres, l'emballage et l'étiquetage, le transport, les méthodes de destruction, les ordonnances, la transmission de renseignements sur les ordonnances à l'autorité centrale, les permis des médecins

autorisés à prescrire des drogues désignées aux patients toxicomanes et la déclaration par les médecins de leurs patients toxicomanes.

The *Misuse of Drugs (Supply to Addicts) Regulations 1997* restreint à quelques médecins détenant un permis spécial l'autorisation de prescrire de l'héroïne, du dipipanone et de la cocaïne pour le traitement de la toxicomanie.

Autres lois pertinentes au domaine de la toxicomanie

La *Medicines Act 1968* réglemente la production et la distribution de médicaments et autres produits médicaux au RU. Il faut habituellement obtenir une autorisation ou permis de marketing avant de distribuer un produit. (Cette loi équivaut à la *Loi canadienne sur les aliments et drogues.*) Cette loi traite des tests, de vente, d'offre, d'emballage, d'étiquetage, des ordonnances, de la délivrance de celles-ci par les pharmaciens et de vente des produits médicaux dans les magasins. Nombre de drogues désignées sont également des produits médicaux et doivent donc être conformes aux exigences de la *MDA* et de la *Medicines Act 1968.*

La *MDA* interdit l'importation ou l'exportation d'une drogue désignée, à moins que celle-ci soit exemptée par règlement ou qu'elle soit inscrite sous le permis approprié. Cependant, il s'agit en réalité d'infractions à la *Customs and Excise Management Act 1979* qui, tout comme la *MDA*, interdit l'importation ou l'exportation non autorisée de drogues désignées. Les infractions à la *Customs and Excise Management Act 1979* donnent habituellement lieu à des mises en accusation et des poursuites par *H.M. Customs and Excise* (douanes et accise de Sa Majesté) plutôt que par la police et les procureurs de la Couronne. En 1997, 1 741 personnes ont été accusées de ces infractions dont 68 % mettaient en cause le cannabis (31 % des cas ont été réglés à l'amiable et 79 % de personnes déclarées coupables ont été condamnées à la détention immédiate).

La partie II de la *Criminal Justice (International Co-operation) Act 1990* contrôle la fabrication et l'offre de certains précurseurs chimiques pouvant servir à la fabrication de drogues illicites. La fabrication et l'offre contraires à la loi constituent un délit de trafic au sens de la *Drugs Trafficking Act 1994.* Il est possible de faire des règlements sur la déclaration des exportations, la tenue de registres et les renseignements fournis.

La *Drug Trafficking Act 1994* a été adoptée pour permettre au RU de respecter ses obligations en vertu de la Convention des Nations Unies contre le trafic illicite de stupéfiants et de substances psychotropes, 1998 (Convention de Vienne). Cette loi crée des infractions en rapport avec le blanchiment et le transport des recettes du trafic des stupéfiants et prévoit des mesures de confiscation. Le fardeau de la preuve incombe au contrevenant tenu de prouver que les biens ont été acquis légalement et applique la norme de preuve civile selon la prépondérance des probabilités. La *MDA* ne fait pas de distinction entre les délits de trafic et les autres infractions. Cette distinction existe plutôt dans la *Drug Trafficking Act 1994*; le fait qu'une infraction soit désignée comme un délit de trafic a pour conséquence principale l'application des dispositions relatives à la

confiscation. De plus, une troisième condamnation pour délit de trafic impliquant une drogue de catégorie A est passible d'une peine minimum de sept ans d'emprisonnement en vertu de la *Crime Sentences Act 1997*.

Débats au RU

Comme au Canada, le débat sur le cannabis au RU semble tourner autour de deux questions soit la décriminalisation ou légalisation du cannabis pour usage ludique, et l'usage médicinal du cannabis.

Même si le cannabis a été placé en Catégorie C, l'usage récréatif du cannabis est, en soi, toujours interdit au RU. Selon la *MDA*, il est illégal de cultiver, de produire, de posséder, ou d'offrir du cannabis à une autre personne. Il est également interdit de permettre que des locaux soient utilisés pour cultiver, préparer, fournir ou fumer du cannabis. Comme au Canada, on utilise beaucoup le pouvoir discrétionnaire pour appliquer la loi et, dans une proportion importante des cas de possession de petites quantités de cannabis, la police *recourait déjà* aux avertissements avant cette modification:

> [Traduction] *« Bon nombre de cas sont traités hors cour, au moyen d'avertissements ou d'arrangements à l'amiable et, en Écosse, de lettres de mise en garde et d'amendes fiscales. En Angleterre et au pays de Galles, l'augmentation la plus considérable des avertissements donnés par la police concerne les délits liés au cannabis : de 41 % en 1990 à 55 % en 1997. Cela signifie que le nombre de contrevenants ayant reçu un avertissement a pratiquement triplé, passant de 16 500 à 47 000. Les avertissements sont mentionnés dans le casier judiciaire d'un contrevenant. Pour le moment, il n'existe aucune disposition prévoyant l'expiration de ces dossiers dans la* Rehabilitation of Offenders Act 1974. *Le gouvernement a récemment publié un document de consultation proposant la correction de cette anomalie et l'expiration immédiate des avertissements. Cela s'appliquerait également aux réprimandes et aux mises en garde, qui doivent remplacer les avertissements pour les jeunes de moins de 18 ans en vertu de la* Crime and Disorder Act 1998.
>
> *L'avertissement n'est pas utilisé par H.M. Customs and Excise ni en Écosse. Pour les délits d'importation et d'exportation, l'arrangement à l'amiable – une peine monétaire plutôt qu'une poursuite – est utilisé dans les cas impliquant une quantité de cannabis de 10 grammes ou moins. Bien que l'arrangement à l'amiable ne soit pas nécessairement inscrit au casier judiciaire du contrevenant, il est parfois mentionné dans des actions en justice subséquentes. Son utilisation pour les délits d'importation de cannabis a diminué de 58 % à 45 %, entre 1990 et 1997.*
>
> *...Le recours au pouvoir discrétionnaire dans l'application de la MDA est souhaitable, mais il engendre des anomalies dans les différentes options d'avertissement et d'arrangement à l'amiable ainsi que des incohérences du taux d'avertissements d'un service de police à l'autre. Plus de la moitié des arrestations pour des délits liés au cannabis aboutissent à un avertissement. Nous ne critiquons pas la police pour son usage extensif de l'avertissement. C'est actuellement la seule réponse réaliste et proportionnelle. Sans lui, les tribunaux seraient engorgés. Mais l'usage du pouvoir discrétionnaire ne diminue en rien*

l'attention disproportionnée que la loi et l'application de la loi donnent au cannabis et à la possession de cannabis en particulier. »[84]

L'usage du cannabis à des fins médicinales a une longue histoire au RU, puisqu'il pouvait être prescrit jusqu'en 1973. Comme nous le verrons dans la section suivante, le *Science and Technology Committee of the House of Lords* recommande dans son rapport de 1998, de permettre l'usage du cannabis à des fins médicinales. Cette recommandation a été rejetée par le gouvernement et celui-ci a déclaré qu'avant d'envisager un tel changement, il faudrait démontrer l'innocuité et l'efficacité du cannabis. La société *GW Pharmaceuticals Ltd* a obtenu l'autorisation de cultiver du cannabis dans le but de fabriquer un médicament à base de cannabis et les essais cliniques ont débuté.

Études et rapports récents

Comité des sciences et de la technologie de la Chambre des Lords

En 1998, le *Science and Technology Committee of the House of Lords* a étudié la question de l'usage médicinal du cannabis et a déposé un rapport intitulé *Cannabis : The Scientific and Medical Evidence.* Le Comité a examiné les faits scientifiques et médicaux concernant l'utilisation médicinale du cannabis et la pertinence des restrictions actuelles et vérifié si l'interdiction de l'usage non médical du cannabis était justifiée en se fondant sur les preuves scientifiques de ses effets nocifs. Toutefois, son mandat ne comprenait pas les aspects sociaux et juridiques de l'utilisation du cannabis.

Le comité a étudié la longue histoire de l'usage du cannabis comme médicament et comme stupéfiant et constaté que «*l'arrivée sur le marché de quantité de médicaments synthétiques nouveaux et meilleurs a mené à l'abandon de nombreux anciens remèdes à base de plantes, notamment du cannabi*s ».[85] La *Medicines Act 1968* permettait au gouvernement d'octroyer des permis aux compagnies pharmaceutiques et d'homologuer les produits et il était encore possible de prescrire le cannabis sous certaines conditions. En 1973, l'homologation du cannabis n'a pas été renouvelée et les règlements de la *Misuse of Drugs Act 1971* interdisaient tout usage médical (en inscrivant le cannabis dans ce qui est devenu l'annexe 1).

Le rapport examine la pharmacologie du cannabis et les différentes voies d'administration, ses effets toxiques à court et à long terme, la tolérance et la possibilité de dépendance. Selon le comité, le cannabis «*n'est pas au premier rang des substances dangereuses, mais les nouvelles recherches tendent à démontrer qu'il est probablement plus dangereux pour la santé qu'on le croyait il y a quelques années seulement*».[86]

---

[84] Police Fondation (2000) *Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, «Drugs and the Law », chapitre 7, paragraphes 28, 29 et 31.

[85] House of Lords, Select Committee on Science and Technology, Ninth Report, Session 1997-98, *Cannabis: The Scientific and Medical Evidence*, par. 2.6.

[86] *Ibid.*, par. 4.1.

Concernant l'utilisation médicale actuelle du cannabis au RU (passablement répandue, bien qu'elle soit illégale) et les usages médicaux des produits dérivés (certains produits dérivés sont utilisés légalement par la médecine au RU), le Comité a proposé de nouvelles indications pour les médicaments à base de cannabis (notamment le soulagement de symptômes associés à la sclérose en plaques). Le comité a déclaré qu'il « *est important de distinguer les différentes substances et préparations; par exemple, il faut faire la distinction entre la feuille et l'extrait de cannabis, et entre le cannabis entier et le THC. Il importe également, bien que ce ne soit pas toujours facile, de distinguer les diverses voies d'administration possibles, par ex., la fumée ou la bouche.* »[87]

Se fondant sur la preuve que le cannabis peut soulager efficacement les symptômes de la sclérose en plaques et d'autres formes de douleur, le comité a recommandé que les essais cliniques sur le cannabis utilisé à ces fins «soient effectués en priorité ». Les membres du comité ont précisé que si un médicament est homologué (après les essais cliniques) le fumage de l'herbe ne devrait pas être le moyen privilégié d'administration. En conséquence, ils ont demandé de poursuivre les recherches sur d'autres voies d'administration. Le comité a recommandé que le cannabis soit classé de nouveau dans l'annexe 2, afin que les médecins soient autorisés à prescrire une préparation de cannabis appropriée, « bien que comme médicament non homologué et nommément désigné » ; cela permettrait également la recherche sans permis spécial.

La compassion constituait le principal motif de la recommandation relative à la modification de la loi (une loi selon laquelle les patients risquent d'être poursuivis en justice pour avoir cherché de l'aide). De plus, le rapport notait que la manière incohérente d'appliquer la loi a jeté le discrédit sur le Parlement et l'administration de la justice.

Selon le comité, un médicament à base de cannabis ne conviendrait pas à certains groupes de patients tels que les femmes enceintes, les personnes prédisposées à la schizophrénie ou souffrant de troubles cardiovasculaires. Il faudrait de plus avertir les usagers des effets secondaires possibles. Le risque d'accoutumance devrait également être envisagé au moment de prendre la décision de prescrire. En conséquence, le comité a recommandé que « *si les médecins sont autorisés à prescrire le cannabis sous forme de produit non homologué, les organismes médicaux professionnels soient tenus de fournir des directives fermes sur la manière de le faire de façon responsable* »[88] *et que* « *les organismes de réglementation professionnelle mettent en place des mesures de garantie pour prévenir le détournement à des fins illégitimes* ».[89]

En ce qui concerne l'usage ludique du cannabis, le comité a souligné que, sans surévaluer les dangers, la preuve des effets toxiques du cannabis était suffisamment étoffée pour justifier le maintien de l'interdiction actuelle.

---

[87] *Ibid.*, par. 5.1.

[88] *Ibid.*, par. 8.16.

[89] *Ibid.*, par. 8.17

Le gouvernement a rejeté la recommandation de reclasser le cannabis. Il a déclaré qu'avant d'autoriser la prescription de cannabis, il faudrait démontrer son innocuité, sa qualité et son efficacité et détenir un permis de marketing délivré par la *Medicines Control Agency*. Le gouvernement a ajouté que le fait d'autoriser la prescription de cannabis réduirait le dynamisme de la recherche. Le gouvernement s'est également dit préoccupé par la possibilité d'utiliser le cannabis d'ordonnance à des fins illégitimes.

En mars 2001, le *Science and Technology Committee of the House of Lords* a présenté un autre rapport traitant de l'état actuel de la recherche sur les usages thérapeutiques du cannabis, les rôles du *Home Office* et de la *Medicines Control Agency* dans l'homologation des médicaments à base de cannabis et des questions plus récentes liées à la poursuite judiciaire des usagers du cannabis thérapeutique. Le comité a réaffirmé que le cannabis devait rester une drogue désignée et qu'il convenait de maintenir une distinction claire entre ses usages thérapeutique et non thérapeutique.

Le comité s'est aussi montré préoccupé par la longueur du délai d'élaboration de préparations thérapeutiques utilisables à partir de ces essais, trouvant plus encourageants les progrès accomplis à la *G.W. Pharmaceuticals Ltd.* quant à l'établissement de l'efficacité d'un médicament à base de cannabis et à l'élaboration de préparations médicales appropriées (un vaporisateur sublingual, par ex.).

Le comité a également discuté de la poursuite des utilisateurs de cannabis à des fins thérapeutiques. Il a constaté que la décision de poursuivre varie d'une région à l'autre et que, dans certains cas, les jurys ont acquitté les utilisateurs thérapeutiques qui ne nient pas l'infraction mais plaident l'usage thérapeutique comme facteur atténuant, tandis que d'autres sont reconnus coupables. Le comité exprimait l'avis que l'acquittement des utilisateurs de cannabis pour des motifs de compassion jetait le discrédit sur la loi. Selon le comité, ce problème confirme la nécessité de légaliser les préparations de cannabis pour usage thérapeutique.

Le comité remarquait aussi des contradictions dans les décisions prises par la *Medicines Control Agency*. À titre d'exemple, l'agence est satisfaite de l'information selon laquelle le profil toxicologique du delta-9-tétrahydrocannabinol est approprié, mais elle n'est pas satisfaite des données toxicologiques sur le cannabidiol. Le comité était d'avis que la *Medicines Control Agency* n'a « pas adopté une approche positive envers l'homologation des médicaments à base de cannabis ». Le comité disait craindre que l'approche de la *Medicines Control Agency* ne place « *les exigences relatives à l'innocuité et les besoins des patients dans un équilibre inacceptable* » et que l'attitude de l'agence « *montre que les médicaments à base de cannabis ne sont pas traités de manière aussi impartiale que les autres médicaments* ».

> [Traduction] « *Nous croyons qu'une nouvelle évaluation complète et impartiale des documents scientifiques publiés sur l'innocuité du CBD et des extraits de cannabis amènera l'agence à revoir sa*

position exagérément prudente. Nous sommes au moins encouragés par la déclaration de l'agence concernant la conduite d'un examen en profondeur des rapports sur le cannabis et le CBD. » [90]

Rapport Runciman

En août 1997, la *Police Foundation* (Fondation de la police) a entrepris une enquête indépendante (présidée par la Vicomtesse Runciman), afin d'évaluer la législation du RU sur l'usage abusif des drogues. Le but principal était de déterminer s'il était nécessaire de réviser la législation afin de la rendre plus efficace et mieux adaptée aux changements survenus au cours des 30 dernières années, soit depuis l'entrée en vigueur de la loi originale.

Reconnaissant que le but d'une loi sur les drogues doit être d'en contrôler et limiter la demande et l'offre, le rapport souligne que l'éradication de l'utilisation des drogues illicites n'est pas un objectif réaliste. Il mentionne également que la loi doit permettre de remplir les obligations internationales du RU en matière de drogues illicites mais observe que les ententes internationales – tout en restreignant certaines options – laissent une marge de manœuvre, notamment dans les domaines de l'usage et de la possession de drogues.[91] Examinant les différentes approches adoptées par d'autres pays européens quant à l'utilisation et la possession de drogues et aux délits d'offre mineurs le rapport démontre que, par comparaison, le régime juridique au RU est beaucoup plus sévère.

Selon le rapport, une loi sur les drogues devrait être fondée sur les principes suivants :

- La loi constitue seulement un des aspects d'un vaste programme de santé, de prévention et d'éducation pour réduire la demande ;
- La loi doit refléter les connaissances scientifiques les plus récentes ainsi que les attitudes sociales et culturelles de la société britannique moderne ;
- Sa mise en application doit être réaliste ;
- Elle doit restreindre la liberté personnelle seulement dans la mesure nécessaire pour limiter les dangers graves menaçant les usagers ou les autres ;
- Elle doit cibler les drogues les plus nocives ;
- Elle doit refléter la nocivité relative des activités liées à chaque drogue ou catégorie de drogues illicites et prévoir des peines proportionnées aux préjudices ; et
- Dans son application, la loi doit être acceptée du public comme équitable, logique, applicable, flexible et juste.

---

[90] House of Lords, Select Committee on Science and Technology, *Therapeutic Uses of Cannabis*, Second Report, 14 mars 2001, par. 29

[91] Report of the Independent Inquiry into the Misuse of Drugs Act 1971, Drugs and the Law, Mars 2000, page 74

Le rapport constate l'augmentation constante de la consommation problématique de drogues (notamment les injections chez les toxicomanes) et de la consommation occasionnelle de drogues au cours des 30 dernières années, le cannabis étant la drogue illicite la plus utilisée. Malgré une augmentation tout aussi constante des délits enregistrés et des saisies effectuées (y compris les quantités saisies) au fil des ans, le rapport conclue à l'échec des efforts de réduction de l'offre. Il démontre que pour le public, les dangers pour la santé sont plus dissuasifs que l'illégalité, la disponibilité ou le prix des drogues. De plus, les attitudes du public envers le cannabis sont considérablement différentes de ses attitudes envers les autres drogues (aux yeux du public, le cannabis est la moins nocive des drogues, sa possession devrait être la dernière priorité de la police et beaucoup de gens – du tiers à la moitié – croient qu'il faudrait assouplir les lois).[92] Tous les groupes d'âge partagent ces opinions, bien que l'appui à la légalisation ne soit pas aussi fort chez les groupes plus âgés. Quant aux autres drogues, les lois rigoureuses en cette matière sont entièrement appuyées malgré l'inquiétude que suscitent les risques pour la santé associés à la consommation. Le public se préoccupe beaucoup plus des délits de trafic que des délits de possession. L'enquête révèle aussi un manque de données sur la consommation de drogues et l'absence d'information détaillée sur les coûts de la consommation (coûts des soins de santé, des services de police et de justice, et d'autres services sociaux, par ex.). Par conséquent, il est difficile d'évaluer les stratégies de contrôle et de prévention en matière de drogues.

Le rapport recommande de conserver le système de classification actuel à trois paliers (catégories A, B et C), jugeant qu'elle permet aux autorités de distinguer les risques relatifs des différentes drogues et d'appliquer des sanctions proportionnées au préjudice causé par la drogue. Cependant, le rapport établit que les critères de classification des drogues ne sont pas clairement décrits. La classification devrait tenir compte du développement des connaissances médicales, scientifiques et sociologiques et le principal critère devrait être la dangerosité de la drogue pour l'individu et la société. Le rapport propose de considérer les facteurs suivants : les risques de la drogue elle-même (toxicité aiguë et chronique) ; les risques associés à la voie de consommation ; les effets de la drogue sur le comportement (toxicomanie/dépendance) et la facilité d'arrêter la consommation ; et les risques sociaux (crimes, coûts médicaux, préjudice social causé par l'intoxication, etc.). Sur la base de ces facteurs, le rapport recommande certains changements aux catégories de drogues pour contrebalancer ce que les membres croient être un message dangereux, c'est-à-dire que toutes les drogues sont également dangereuses. Les membres du comité considèrent que ces changements amélioreraient la crédibilité de la loi et qu'il faudrait recentrer l'éducation et l'attention sur les drogues plus nocives telles que l'héroïne et la cocaïne. Le rapport recommande donc les changements suivants :

---

[92] *Ibid.*, Chapitre 2, par. 64.

- Reclasser le cannabis de la catégorie B à la catégorie C et les cannabinols de la catégorie A à la catégorie C ;
- Laisser l'héroïne et la cocaïne dans la catégorie A (la catégorie des drogues les plus dangereuses) et transférer l'ecstasy et le LSD dans la catégorie B ; et
- Transférer la buprémorphine de la catégorie C à la catégorie B.

Il est intéressant de noter que les membres du Comité auraient classé l'alcool comme drogue de catégorie B à la limite de la catégorie A et le tabac à la limite des catégories B et C, si ces substances avaient été désignées en vertu de la *MDA*.

Le rapport établit qu'il faudrait maintenir les délits de possession, même pour la consommation personnelle, mais que la loi devrait minimiser les conséquences préjudiciables selon les délits. Le rapport conclut que pour la plupart des délits de possession, l'emprisonnement n'est ni proportionné ni efficace. Il recommande de supprimer l'emprisonnement pour possession de drogues des catégories B et C. L'incarcération reste une possibilité pour la possession de drogues de catégorie A, mais les durées maximales seraient inférieures à celles qui sont prévues actuellement. Une telle modification refléterait d'ailleurs ce que les tribunaux font présentement; la peine moyenne pour possession étant passablement plus courte que le maximum prévu. De plus, le rapport recommande de diminuer les amendes maximales pour toutes les catégories de drogues. Selon le rapport, l'incarcération pour possession devrait être rare. Les peines en milieu ouvert incluraient les amendes, les ordonnances de probation, les ordonnances de probation avec obligation de traitement et les libérations conditionnelles. Ces sanctions conviendraient mieux à la possession des drogues de catégorie B et C où un avertissement n'est pas approprié. Comme nous l'avons noté plus haut, le rapport indique que dans plus de la moitié des cas, la police donne déjà un avertissement. Pour mieux encadrer le pouvoir discrétionnaire, il faudrait inclure l'avertissement dans les sanctions prévues par la loi et décrire les directives le concernant dans les règlements. Cela permettrait d'exiger que les conditions rattachées à l'avertissement soient remplies. Enfin, le rapport recommande que l'avertissement ne soit pas inscrit au casier judiciaire. Si on donne suite à la recommandation concernant le transfert du cannabis dans la catégorie C, il y aura certaines conséquences, dont le fait que la police ne soit plus autorisée à arrêter un individu pour possession de cannabis. Pour les infractions passibles d'arrestation, la police possède le pouvoir d'insister pour que les suspects l'accompagnent au poste de police et de fouiller leurs locaux sans mandat. La police conserverait cependant le pouvoir de faire des arrestations et de chercher toutes les drogues.

En ce qui concerne le trafic, le rapport suggère de distinguer les délits selon leur gravité (par exemple, l'offre entre amis et l'offre faite par un membre d'un groupe criminel organisé; l'offre de drogues de catégorie A et celle d'autres drogues). Le rapport recommande une infraction séparée pour le commerce, dont l'élément principal serait le modèle d'activité des transactions illégales de drogues. L'infraction

constituerait un délit de trafic aux fins de la *Drugs Trafficking Act 1994*. Le rapport recommande que la peine maximale pour trafic de drogues de catégorie A soit réduite à 20 ans et que le maximum pour les drogues de catégorie C (y compris le cannabis) soit augmenté à sept ans. Le rapport recommande également l'approbation de lignes directrices sur la détermination de la peine, notamment pour les délits de trafic. Celles-ci détermineraient les circonstances aggravantes, notamment l'implication dans le crime organisé, le recours à la violence ou l'usage d'armes à feu, l'implication de mineurs, le lieu de l'infraction, etc. De plus, le rapport mentionne l'inefficacité des lois traitant de la confiscation des biens (selon les auteurs, il s'agit d'un problème pragmatique plutôt que législatif). Le rapport recommande d'améliorer l'efficacité du système actuel en créant un nouvel organisme national de confiscation et en faisant plusieurs autres changements.

Pour mettre en œuvre ces recommandations, il ne serait pas nécessaire de modifier radicalement la législation sur les drogues, sauf en matière de cannabis. En conséquence, les changements les plus importants s'appliquent à cette drogue. Les membres de la commission soulignent que le cannabis est moins nocif pour l'individu et la société que les autres drogues illicites (bien qu'il ne soit pas inoffensif) et que la loi actuelle cause plus de tort qu'elle n'en prévient et qu'elle est disproportionnée par rapport au préjudice causé par la drogue. Le rapport recommande donc de réduire les peines pour possession de cannabis pour usage personnel et notamment d'éliminer les peines d'emprisonnement. Les poursuites pour culture de petites quantités de cannabis devraient être intentées en vertu de l'article 6 (culture du cannabis) plutôt que l'article 4 (production), de sorte que l'infraction ne serait pas considérée comme un délit de trafic. Il faudrait traiter le délit de culture de la même manière qu'un délit de possession de cannabis. De plus, fumer du cannabis dans des lieux privés ne constituerait plus un délit. Selon le rapport, les avantages d'une telle stratégie l'emportent sur les risques et cela permettrait de cibler l'application de la loi sur les drogues et les activités les plus préjudiciables.

En ce qui concerne la réduction de la demande le rapport conclut que la loi pénale a peu d'effets mais que les mesures d'éducation et de traitement peuvent être plus efficaces. Les membres de la commission recommandent donc une approche moins punitive pour les délits de possession mais plus punitive pour les délits de trafic (notamment en ce qui concerne les profits réalisés illicitement). La toxicomanie étant d'abord un problème de santé individuelle et publique avant d'être un problème de criminalité, le rapport recommande de réaffecter une partie importante des ressources d'application de loi (actuellement 62 % des dépenses) au traitement (actuellement 13 %).

Sur l'utilisation médicale du cannabis, le rapport conclut que les avantages thérapeutiques du cannabis pour certaines maladies graves l'emportent sur les dommages potentiels. Les auteurs partagent l'opinion exprimée dans le rapport de la Chambre des Lords recommandant que le cannabis et la résine de cannabis soient transférés à l'annexe 2 (autorisant ainsi la possession et l'offre à des fins médicales).

Comme le gouvernement a rejeté la recommandation de la Chambre des Lords et qu'il faudra des années avant qu'un produit à base de cannabis soit homologué et disponible, les auteurs du rapport recommandent un nouvel élément de défense en droit : la contrainte de circonstances pour des raisons médicales, pour les personnes accusées de posséder, de cultiver ou d'offrir du cannabis dans le but de soulager les symptômes de certaines maladies.

Dans sa réponse au rapport, le gouvernement a rejeté les recommandations ou proposé de les étudier plus tard. Il n'a pas accueilli favorablement les recommandations sur la question clé de la reclassification du cannabis – se disant préoccupé par les risques pour la santé associés à sa consommation – ni sur sa dépénalisation – refusant de supprimer la peine d'emprisonnement de la liste des sanctions possibles. La réponse du gouvernement s'opposait aussi à l'abolition du pouvoir d'arrestation des policiers concernant ces infractions. Concernant l'usage médical du cannabis, le gouvernement réaffirmait qu'il faut démontrer la qualité, l'efficacité et l'innocuité d'une forme médicinale de la drogue avant d'en autoriser la prescription.

On sait que, depuis lors, le gouvernement a effectivement reclassifié le cannabis et aboli les peines d'emprisonnement pour possession pour usage personnel.

Autres rapports

Un groupe de travail du *Royal College of Psychiatrists* et du *Royal College of Physicians* a également publié un rapport en 2000. Intitulé *Drugs: Dilemmas and Choices*, le rapport examine certaines questions clés concernant la prévention de la toxicomanie. Ce rapport observe notamment :

> [Traduction] *« Dépenses pour la prévention : Les trois quarts des dépenses du RU sont consacrés à l'application de la loi et à la réduction de l'offre internationale. Rien ne prouve que cet argent est bien dépensé. Mais la rentabilité établie des traitements d'entretien à la méthadone et des programmes fondés sur l'abstinence pour les héroïnomanes indique qu'il faudrait consacrer une plus grande partie du budget disponible aux programmes de traitement. Les fonds additionnels pour le traitement annoncés par le gouvernement sont les bienvenus, mais il faut résister aux demandes d'expansion pour les traitements n'ayant pas été mis à l'épreuve ou testés.*
> *Recherche : Au RU, les dépenses actuelles en recherche sur les drogues sont loin de correspondre à l'ampleur du problème. Seulement 1 % du budget annuel de prévention de la toxicomanie injecterait 14 M£ dans la recherche – soit plus du double du montant dépensé présentement.*
> *Amélioration de la valeur du traitement : Il faut investir systématiquement dans la formation du personnel, la surveillance des patients, et les services de soutien essentiels pour que les taux d'amélioration des programmes de traitement du RU atteignent un niveau comparable à ceux des États-Unis. Il faut notamment augmenter le nombre des centres de traitement pour adolescents toxicomanes.*
> *Prescription privée : La prescription privée de drogues de remplacement laisse place à la négligence professionnelle qui s'apparente à l'« achat d'une ordonnance ». Actuellement, les médecins qui traitent les toxicomanes sans être affiliés à un service de santé ne sont pas tenus d'avoir une formation spécialisée en toxicomanie et sont peu surveillés ou peu soumis à des règlements.*
> *Dépistage de la toxicomanie par les employeurs : Bien qu'elle soit coûteuse et entourée de problèmes juridiques et déontologiques, il existe une technologie pour dépister la toxicomanie chez les employés à*

l'aide d'échantillons de cheveux. Elle fournit un dossier sur la consommation de drogues au cours des trois mois précédents le test et, par conséquent, elle pourrait avoir une incidence considérable sur la fréquence de la consommation de drogue dans l'avenir.
Ecstasy : Beaucoup de jeunes consomment de l'ecstasy et certaines campagnes d'éducation en matière de toxicomanie se sont révélées improductives. En conseillant les jeunes, il faut tenir compte de l'impact éventuel sur ceux qui continueront de consommer des drogues et sur ceux qui seront dissuadés.
Amphétamines : La dépendance aux amphétamines, notamment sous forme injectable, comporte probablement plus de risques pour la santé individuelle et publique que la dépendance à l'héroïne. Il y a peu de recherche sur la dépendance et le traitement.
Cannabis : Le cannabis n'est pas une drogue inoffensive, mais ses effets indésirables sur la santé sont presque certainement moindres que ceux du tabac et de l'alcool, qui sont des produits légaux. Il faut poursuivre les recherches sur les avantages thérapeutiques et les effets indésirables à long terme de cette drogue. Il faudrait encourager les expériences législatives, comme aux Pays-Bas. Les gens qui demandent du cannabis pour soulager les symptômes d'une maladie, comme la sclérose en plaques, ne devraient pas être poursuivis en justice.
Politique future : La stratégie décennale de lutte contre la toxicomanie du gouvernement reconnaît la nécessité d'investir davantage dans le traitement. Mais il n'y a pas de réponse facile et les projets modestes annoncés jusqu'ici ne suffiront probablement pas pour atteindre l'objectif ambitieux de réduire de moitié la proportion de jeunes consommateurs d'héroïne et de cocaïne d'ici 2008. Les tentatives de restriction du commerce international illicite des drogues ont échoué de manière constante et continueront probablement de le faire. Si la fréquence de la toxicomanie et des crimes connexes continue d'augmenter, il y aura certainement un accroissement des pressions exercées sur le RU et les autres gouvernements afin de modifier les politiques dont l'inefficacité est évidente. »[93]

Administration

Le problème de la drogue étant complexe, plusieurs ministères et organismes différents participent à la mise en application de la stratégie sur la toxicomanie du RU. Les principaux organismes sont les équipes d'intervention en toxicomanie (*drug action team*) chargées de veiller à ce que la stratégie se traduise en mesures concrètes à l'échelle locale.

Coûts

Coûts publics

En 1997-1998, la plupart des dépenses portaient sur l'application de la loi. Une somme totale de 1,4 MM£ a été dépensée pour les activités suivantes :

- *La toxicomanie, l'application de la loi et la réduction de l'offre internationale* représentent 75 % (l'application de la loi comprend la police, les tribunaux, la probation et les prisons – 62 %; l'offre internationale, englobant les douanes et accise, ainsi que le *Foreign and Commonwealth Office* – 13 %) ;

[93] Joseph Rowntree Foundation, *Drugs: dilemmas, choices and the law*, novembre 2000. Voir cet article à l'adresse suivante : http://www.jrf.org.uk/knowledge/findings/foundations/N70.asp

- Traitement et réhabilitation – 13 % ;
- Éducation et prévention – 12 %.[94]

À la suite de l'examen complet des dépenses publiques en 1998, un montant additionnel de 217 M£ a été affecté aux activités relatives aux drogues sur une période de trois ans. « Une partie importante de ces fonds servira à financer les projets destinés à briser le lien entre la toxicomanie et le crime, notamment les options de la procédure d'arrestation, le traitement de la toxicomanie et les ordonnances de dépistage. L'intention est de donner à chaque toxicomane détenu dans un poste de police ou une prison la possibilité de suivre un traitement d'ici l'an 2002 ».[95] Les fonds supplémentaires seront dépensés comme suit :

- 133 M£ pour la mise en application de la stratégie de lutte contre la toxicomanie dans le système judiciaire pénal ;
- 60 M£ pour les services de traitement et 12 M£ pour le dépistage volontaire de la toxicomanie en milieu carcéral ;
- 61 M£ pour la mise en application des ordonnances de dépistage et de traitement de la toxicomanie (*Drug Treatment & Testing Orders*) ;
- 70,5 M£ aux autorités locales et de santé, afin de financer les services de traitement et d'améliorer les soins communautaires pour les toxicomanes ;
- 50 M£ pour les services de traitement et les jeunes à risque ;
- 20,5 M£ pour les autorités locales afin d'améliorer l'accès aux services et augmenter le nombre des programmes de traitement ;
- 10,5 M£ pour supporter les équipes d'intervention en toxicomanie de tout le pays et la recherche nationale sur l'efficacité d'une activité antidrogue ;
- 3 M£ pour l'élaboration de programmes interministériels plus efficaces d'éducation en matière de drogues ;
- 6 M£ répartis sur 3 ans pour un nouveau programme de recherche ; et
- 3 M£ sera réservé au fonds des biens confisqués en 1999-2000, qui sera augmenté à 5 M£ et 7 M£ dans les années subséquentes.[96]

Coûts sociaux

Le rapport annuel 1999-2000 du coordonnateur antidrogue du RU démontre que la toxicomanie a coûté à l'État plus 4 MM£ en crimes, maladie et absentéisme. On estime de plus que le tiers des crimes contre les biens est lié aux drogues.

---

[94] Tackling Drugs to Build a Better Britain, The Government's Ten-Year Strategy for Tackling Drugs Misuse, avril 1998, dans le chapitre intitulé : « Resourcing and Managing the Work ».

[95] DrugScope, *UK Drug Situation 2000.* Rapport du RU au European Monitoring Centre for Drugs and Drug Addiction, novembre 2000, page 7.

[96] *Ibid.*, pages 11-12.

Statistiques

Selon les estimations du *Office for National Statistics*, le marché des drogues illicites représente à lui seul près de 1 % de la production nationale, soit l'équivalent de 8,5 MM£ par année.[97]

Malgré les critiques que certains rapports ont faites, le RU dispose d'une base de données impressionnante sur l'observation des tendances d'usage des drogues. Ainsi, depuis 1983, le Home Office mène, à tous les deux ans, une enquête nationale – le *British Crime Survey* – qui inclut notamment une série de questions sur l'usage de drogues illicites. Le Home Office tient aussi des séries de données détaillées sur les arrestations, les condamnations et les sentences. L'organisme *DrugScope* est le correspondant britannique pour l'OEDT.

Consommation

Dans le groupe des 16 à 59 ans, 32 % des répondants en l'Angleterre et au pays de Galles déclarent avoir «déjà utilisé une drogue » (29 % en 1996 et 28 % en 1994). Ce pourcentage augmente à 50 % dans le groupe des 16 à 24 ans. Cependant, la consommation récente de drogue est moins courante. Ainsi, dans les enquêtes de 1994, 1996 et 1998, 10 % à 11 % déclarent avoir consommé de la drogue au cours de l'année passée et 6 % au cours du mois passé. La consommation de drogues varie avec l'âge : 30 % des 16 à 24 ans signalent avoir consommé de la drogue au cours de l'année passée et 20 % au cours des derniers 30 jours (en comparaison de 3% et 1,5 % chez les 45 à 54 ans). En outre, la consommation de drogues est plus fréquente chez les hommes que chez les femmes. Quant aux enfants, les enquêtes menées en Angleterre révèlent que 13 % des répondants âgés de 11 à 15 ans déclarent avoir déjà consommé de la drogue. Chez les jeunes, la fréquence augmente avec l'âge : 3 % des 11-12 ans, 13 % des 13-14 ans et 31 % des 15 ans déclarent avoir déjà consommé de la drogue.

Le cannabis est la drogue illicite la plus cultivée, la plus vendue et la plus consommée au RU. La consommation est plus courante chez les jeunes et diminue avec l'âge. En Angleterre et au pays de Galles, presque la moitié des 16 à 24 ans déclarent avoir déjà consommé du cannabis, dont 17 % au cours du mois dernier. Seulement 5 % des adultes de 55 à 59 ans affirment avoir déjà consommé cette drogue.

Infractions

Les contrevenants arrêtés au RU font parfois l'objet de procédures différentes, notamment l'avertissement par la police ou la poursuite en justice (sauf en Écosse où d'autres procédures sont disponibles). En vertu de la *Customs and Excise Act 1979*, l'arrangement à l'amiable (le paiement d'une somme d'argent plutôt qu'une poursuite) est possible dans les cas d'importation de quantités minimes de cannabis (10 grammes ou moins). De plus, les autorités utilisent parfois leur pouvoir discrétionnaire et ne

---

[97] « The Untouchables », *Economist*, 21 avril 2001, vol. 359, nº 8218, page 49

prennent pas d'autres mesures. Cette dernière option n'apparaît pas dans les statistiques criminelles.

Le nombre de personnes arrêtées pour des infractions liées à la drogue est passé de 35 000 en 1988 à 153 000 en 1998. Parmi elles, 127 840 ont été reconnues coupables ou ont reçu un avertissement, ont payé une amende ou ont réglé à l'amiable. En 1997, leur nombre était de 113 150.

La drogue la plus courante est le cannabis (76 %). Près de 90 % des infractions à la *MDA* sont des délits de possession et, habituellement, les trois quarts de l'ensemble des délits de possession impliquent le cannabis.

Le nombre d'avertissements donnés a augmenté énormément au fil des ans et représente près de la moitié de l'ensemble des condamnations, des avertissements, des amendes et des arrangements à l'amiable. Bon nombre de cas sont donc réglés sans procès.

En 1998, le nombre de saisies de drogues s'élevait à 149 900, soit 8% de plus qu'en 1997. Le cannabis était en cause dans 76 % des cas. Enfin, entre 1995 et 1999, le prix moyen de la plupart des drogues est demeuré relativement stable.

LA SUÈDE[98]

Lorsqu'ils opposaient un modèle réussi à « l'échec » néerlandais, les témoins que nous avons entendus mentionnaient invariablement la Suède. En Suède, le phénomène de la drogue est considéré comme l'un des plus graves problèmes sociaux (sinon le plus grave) et les drogues sont perçues comme une menace extérieure au pays.[99] On considère souvent la toxicomanie comme la cause d'autres problèmes sociaux et le problème de la drogue comme mettant en péril les valeurs traditionnelles de la Suède. Ces préoccupations se sont intensifiées depuis que la Suède est devenue membre de l'Union européenne (UE) en 1995, puisque la plupart des autres membres de l'UE ont adopté une attitude plus libérale relativement aux questions de drogue. Si l'on compare avec d'autres pays de l'Europe occidentale, la politique de la Suède en matière de drogue est effectivement restrictive. Un des objectifs de cette politique est d'indiquer très clairement que les drogues ne sont pas tolérées dans la société et son but est celui d'une société sans drogue. On observe notamment que :

- Les programmes de réduction des méfaits sont limités ;
- Le traitement vise l'abstinence complète et il est possible d'obliger les toxicomanes à suivre un traitement ;
- La consommation de stupéfiants est une infraction à la loi et la politique prévoit des analyses sanguines et d'urine pour dépister ceux que l'on soupçonne de faire usage de drogues ;
- Les lois sont appliquées sévèrement ;
- Les discussions au sujet de la valeur médicale du cannabis sont presque inexistantes ; et
- Les lois suédoises respectent de façon stricte et même dépassent les exigences établies dans les trois conventions des Nations Unies sur les drogues.

Bien que la politique suédoise en matière de drogue soit actuellement très restrictive, il n'en a pas toujours été ainsi. En fait, au cours des années 1960, elle était relativement libérale, fondée principalement sur une démarche de réduction des méfaits.[100] Par exemple, de 1965 à 1967, il était possible, pour les toxicomanes

---

[98] Cette section s'inspire largement du rapport préparé par la Bibliothèque du Parlement pour le Comité : Lafrenière G., (2001) Politique nationale sur les drogues : la Suède. Ottawa : Bibliothèque du Parlement, rapport préparé pour le Comité spécial du Sénat sur les drogues illicites, disponible en ligne à www.parl.gc.ca/drogues-illicites.asp Pour plus d'informations, lire aussi : Boekhout van Solinge, T., (1997) *The Swedish Drug Control System : An in-depth review and analysis*, Amsterdam : Centre for Drug Research, University of Amsterdam.

[99] European NGO Council on Drugs and Development, *A Snapshot of European Drug Policies : Report on the state of drug policies in 12 European countries*, octobre 2001, p. 27.

[100] United Nations Office for Drug Control and Crime Prevention, *Country Drug Profile : Sweden*, 1998, page 1

extrêmement dépendants, d'obtenir une ordonnance de morphine et d'amphétamines. Cette « expérience », à laquelle ont participé environ 120 personnes, a par la suite été utilisée par Nils Bejerot, médecin policier et personnage très influent dans le milieu de la politique suédoise en matière de drogue, dans son analyse du lien entre l'usage de la drogue et la politique en matière de drogue au cours de la période de 1965 à 1970. Bejerot concluait notamment que les changements d'une politique restrictive à une politique permissive, et vice versa, avaient eu une incidence sur le taux d'usage de drogues intraveineuses, que cette expérience avait été à l'origine de l'épidémie de drogue en Suède, et qu'elle n'avait pas eu l'effet souhaité de réduction de la criminalité. Ses conclusions, encore largement acceptées en Suède, ont cependant fait l'objet de multiples critiques.[101]

Devant l'accroissement de l'usage des drogues, un Comité sur le traitement des toxicomanes a été formé en 1965, publiant quatre rapports entre 1967 et 1969. Le premier portait sur le traitement et le second sur les mesures répressives. C'est ce second rapport qui a mené à l'adoption de la *Loi sur les stupéfiants* en 1968. Les rapports du Comité indiquaient que le problème des drogues allait en s'intensifiant. Cette conclusion, associée à celle de Bejerot, est en partie à l'origine de la démarche plus restrictive adoptée par la Suède vers la fin des années 1960. En outre, depuis 1968, le gouvernement a organisé une campagne antidrogue massive dans les écoles et les médias, de sorte qu'une génération a grandi parmi les messages fondés sur la théorie de la drogue d'introduction, entre autres.[102] Cette théorie sert à justifier les restrictions relatives au cannabis et [traduction] « *la politique suédoise sur la drogue porte principalement sur le cannabis, puisqu'on allègue que les "carrières dans le domaine de la drogue" commencent par cette substance* ».[103] En outre, les dangers causés par le cannabis lui-même (psychose, propension à la dépendance, risque élevé de suicide, etc.) sont considérés comme une justification valable à une politique restrictive.

Cette politique restrictive s'est poursuivie au fil des ans et a mené à une intensification des sanctions, la criminalisation de l'usage des drogues et l'autorisation des analyses sanguines et d'urine pour ceux que l'on soupçonnait de faire usage de drogues. Bien qu'à l'origine, le but des analyses sanguines et d'urine ait été de dépister les nouveaux consommateurs de drogue et de leur offrir un traitement approprié, il semble qu'elles ne soient plus destinées à cette seule fin puisque les toxicomanes connus sont maintenant ciblés.[104]

Certains auteurs ont établi un lien entre la politique restrictive de la Suède en matière de drogue et sa politique restrictive à l'égard de l'alcool. Le mouvement de tempérance a des origines lointaines en Suède et ce pays a établi une politique assez restrictive relativement à l'alcool, de même qu'un monopole d'État pour la vente d'alcool.

---

[101] Boekhout van Solinge, *op. cit.*, page 45.
[102] European NGO Council on Drugs and Development, *op. cit.*, page 27.
[103] Boekhout van Solinge, *op. cit.*, page 88.
[104] *Ibid.*, pages 116-117.

[Traduction] *« Les attitudes des Suédois à l'égard de l'alcool sont pertinentes puisqu'une politique restrictive à ce sujet rend tout à fait logique l'établissement d'une politique restrictive en matière de drogue. De plus, le modèle de consommation totale sur lequel repose la politique à l'égard de l'alcool, est considéré également valide pour les drogues illicites. En limitant la consommation totale de stupéfiants, on s'attend à ce que les préjudices totaux causés par les drogues soient aussi plus faibles. Cependant, on a démontré que cette corrélation était loin d'être évidente pour différentes drogues illicites. »* [105]

Stratégie nationale

À la suite de la création d'une Commission sur les stupéfiants, le gouvernement suédois a présenté un nouveau plan d'action, en janvier 2002, qui sera valide jusqu'en 2004. Un total de 325 millions de couronnes suédoises (SEK) (environ 50 millions $ canadiens) a été affecté, pour cette période de trois ans, à la lutte antidrogues. Le plan d'action a été présenté comme un moyen de renverser la tendance inquiétante de l'usage de drogues.[106]

Cette politique vise à :

- Réduire le nombre de nouvelles recrues dans le monde de la toxicomanie (principalement par des mesures de prévention ciblant les jeunes) ;
- Encourager les toxicomanes à renoncer à leur comportement (par des soins et un traitement) ; et
- Réduire l'offre de drogues (par la prise de mesures au criminel).

Une des caractéristiques de la stratégie antidrogues est la création d'un poste de coordonnateur national antidrogues. Ce poste a été institué en vue de fournir un leadership clair en matière de politique sur les drogues, d'assurer le suivi des objectifs du plan et de déterminer s'il faut entreprendre de nouvelles initiatives pour combattre de nouveaux problèmes. Ses principales tâches sont les suivantes :

- Assurer une coopération avec les autorités, les conseils municipaux et les conseils de comté, les ONG, etc. ;
- Influer sur l'opinion publique ;
- Assumer une fonction de soutien auprès des conseils municipaux et de comté pour l'élaboration de stratégies locales ;
- Amorcer des travaux de recherche et de développement en vue de la mise au point de méthodes ;
- Servir de porte-parole du gouvernement pour les questions touchant les stupéfiants ;
- Évaluer le plan d'action ; et

---

[105] *Ibid.*, p. 103

[106] Ministère de la Santé et des Affaires sociales, *National Action Plan on Narcotic Drugs*, Fiche d'information, février 2002.

- Rendre compte régulièrement de ses activités au gouvernement (au moins une fois par année).

Des 325 millions SEK, 100 millions (soit environ 15 millions $ canadiens) ont été affectés à une initiative spéciale sur les drogues au sein du Service suédois de probation et de détention. Le but de cette initiative est d'offrir des soins et un traitement à tous les toxicomanes du système. De plus, l'administration nationale des probations et des établissements de détention doit :

- Mettre au point des méthodes de prévention de l'introduction de drogues dans les établissements et les centres de détention ;
- Examiner les obstacles au traitement en dehors des établissements ; et
- Établir des programmes spéciaux pour les soins fournis en vertu de contrats, c'est-à-dire des soins fournis conformément à un contrat passé entre le condamné et la collectivité.

Pour ce qui est de la police, le Conseil national de police et le Conseil national de prévention du crime devront entreprendre leur propre examen des efforts déployés par les policiers dans la lutte contre le crime lié à la drogue.

En Suède, si la politique est établie au niveau national, une grande part de la mise en œuvre des objectifs du plan d'action relève des municipalités. Ainsi, ces dernières doivent s'occuper des toxicomanes conformément à la *Loi sur les services sociaux*. Les initiatives de prévention sont aussi appliquées au niveau local. Les stratégies des municipalités seront donc axées sur des préoccupations locales. L'application de la *Loi* continue toutefois de se faire au niveau national, par l'intermédiaire des services des douanes et de police.

Le traitement figure parmi les trois piliers de la politique suédoise en matière de drogue. Un des objectifs de cette politique est de réadapter les toxicomanes, plutôt que de les punir au moyen du système de justice pénale. Depuis 1982, on peut obliger les personnes à suivre un traitement pour toxicomanie (qui s'applique aussi à l'alcool et à d'autres substances) pour une période allant jusqu'à six mois. La principale justification de ce genre de traitement est de protéger le toxicomane ou d'autres personnes et de motiver le toxicomane à poursuivre le traitement volontairement. Le recours au traitement obligatoire semble toutefois peu courant et son efficacité a été remise en question.[107] Au cours des dernières années, on a constaté une réorientation du traitement obligatoire et du traitement en établissement vers un traitement ambulatoire. Il semble cependant que le traitement soit aujourd'hui moins facilement accessible qu'il ne l'était il y a 10 ou 15 ans. De plus, la durée de traitement des toxicomanes a diminué. Ces changements sont attribuables aux coupures effectuées durant les années 1990 dans les dépenses municipales au chapitre des services sociaux : [traduction] « *Tandis qu'en 1989, on avait dénombré 19 000 personnes dans les centres de désintoxication (pour*

[107] Boekhout van Solinge, *op. cit.*, page 165.

alcooliques et toxicomanes), en 1994, le nombre n'était plus que de 13 000. Pendant la même période, le nombre de personnes en traitement forcé était passé de 1 500 à 900. À cause des restrictions budgétaires, 90 centres de traitement ont fermé leurs portes entre 1991 et 1993. »[108]

Les programmes de traitement de substitution à la méthadone existent en Suède depuis la fin des années 1960. Actuellement, environ 600 personnes sont inscrites à des programmes de traitement de substitution à la méthadone à Stockholm, Uppsala, Malmo et Lund. Les programmes sont strictement réglementés et sont officiellement considérés comme étant expérimentaux. Les conditions de participation prévoient que le patient doit avoir plus de 20 ans et doit utiliser des opiacés par intraveineuse depuis au moins quatre ans, il doit avoir essayé plusieurs formes de traitement pour toxicomanie et il doit s'être inscrit au programme volontairement (par exemple, il ne doit pas être détenu, ni en état d'arrestation, ni condamné à une période d'emprisonnement, ni être détenu dans un établissement correctionnel). Pour les participants aux programmes de traitement de substitution à la méthadone, aucune autre drogue n'est autorisée et le patient doit visiter la clinique quotidiennement. Actuellement, le nombre maximal de personnes pouvant participer au programme en même temps est de 800. Des projets pilotes sont en cours avec Subutex.

Bien que la Suède ait consacré de grandes sommes au traitement, très peu de ses programmes ont fait l'objet d'une évaluation. Par conséquent, il est difficile de donner des détails sur leur efficacité. [Traduction] « *L'objectif officiel est de réadapter les toxicomanes, et les moyens financiers, ainsi que les efforts affectés à cette fin sont énormes, bien plus importants que dans beaucoup d'autres pays européens. Cependant, malgré toutes ces bonnes intentions, il reste que l'efficacité de ces programmes expansifs est relativement faible. À long terme, les programmes de désintoxication de la Suède n'ont pas obtenu de meilleurs résultats que ceux que l'on trouve ailleurs, à l'échelle internationale* ».[109]

En ce qui concerne les initiatives de réduction des méfaits, on trouve peu de services de bas seuil en Suède et la plupart d'entre eux sont assurés par des organisations bénévoles. Ces organisations offrent une série de services, mais toutefois pas d'ordonnances. Des programmes d'échange de seringues sont appliqués dans les cliniques pour maladies infectieuses des hôpitaux de Lund et de Malmo et sont donc assez limités. Les initiatives de réduction des méfaits, comme les programmes d'échange de seringues, sont difficiles à promouvoir dans une société qui vise l'élimination complète des stupéfiants et où la consommation de drogue n'est pas acceptée. Une proposition de la fin des années 1980, qui consistait à mettre en place des programmes d'échange de seringues dans toute la Suède, a été refusée par le Parlement qui a jugé qu'une [traduction] «*plus grande disponibilité de seringues n'empêcherait pas la propagation du VIH, mais allait tout au contraire augmenter l'utilisation des drogues injectables* ».[110]

---

108 *Ibid.*, page 125.
109 *Ibid.*, page 162.
110 *Ibid.*, page 129.

Le système de justice criminelle a aussi un rôle à jouer en ce qui concerne le traitement. En 2000, plus de 5 000 toxicomanes ont été mis en détention. Tandis qu'ils sont en prison, les contrevenants ont accès à des programmes de désintoxication et certains d'entre eux sont transférés hors des établissements pénitentiaires pour leur traitement. Il existe aussi des initiatives visant à empêcher l'introduction de drogues dans les prisons, par exemple par des perquisitions et des analyses d'urine. Pendant leur séjour en prison, les contrevenants n'ont droit à aucune seringue ni à aucun traitement de substitution.

La législation permet, dans certaines conditions, à un contrevenant de purger sa sentence hors de la prison. Le traitement forcé pour toxicomanie est l'une des raisons souvent invoquées. Une autre solution de rechange à l'emprisonnement est l'imposition d'une période de probation combinée à un traitement pour toxicomanie en établissement. Voici un exemple de solution de rechange à l'emprisonnement

> [Traduction] *« Depuis 1998, les personnes ayant un problème de toxicomanie et ayant commis une infraction liée à la drogue peuvent avoir accès à un traitement en signant une « convention de traitement ». Il s'agit d'un contrat réel passé entre le toxicomane et le tribunal, en vertu duquel les deux parties ont des droits et des obligations, comme dans tous les contrats. Cependant, certaines conditions doivent être remplies par le toxicomane : la personne en question doit avoir besoin d'un traitement et doit être prête à s'y soumettre; elle est toxicomane; la toxicomanie a contribué au crime commis, qui ne doit pas être grave (sanction prévue de moins de deux ans). La personne n'est alors pas envoyée en détention et un plan de traitement personnalisé est établi pour elle. Les autorités de la santé sont responsables du traitement et doivent informer l'administration locale des probations et des établissements de détention, ainsi que le ministère public si le probationnaire néglige sérieusement les obligations mentionnées dans son plan personnel. »* [111]

En ce qui concerne la prévention, les programmes d'information sur les drogues commencent tôt et figurent à tous les niveaux du programme scolaire. [Traduction] « *Sans exagération, ce programme "d'influence d'opinion" pourrait être décrit comme un processus d'endoctrinement. Compte tenu de l'ampleur de ces programmes, il est devenu incontestable et irréfutable que leur contenu fasse partie du système de valeurs de chacun* ».[112]

Quant au cannabis, il est classé au nombre des drogues dangereuses et [traduction] « *son usage est considéré comme le point de départ de la toxicomanie* ».[113] C'est l'une des raisons pour lesquelles les mesures de prévention portent une attention particulière au cannabis puisqu'il devrait mener à une baisse de l'expérimentation des drogues qui empêchera les nouvelles recrues d'accéder au milieu.

---

[111] Observatoire européen des drogues et des toxicomanies, *Country Profiles – Sweden*, European Legal Database on Drugs, 2001

[112] *Ibid.*, page 177.

[113] Boekhout van Solinge, *op. cit.*, page 15.

Cadre législatif

Catégories de stupéfiants

La principale loi s'appliquant aux drogues en Suède est la *Loi sur les stupéfiants de 1968*. Les « stupéfiants » y sont définis à l'article 8, et comprennent les médicaments ou les substances dangereuses pour la santé qui ont des propriétés toxicomanogènes et dont l'usage est restreint en vertu d'une entente internationale dont la Suède est signataire, ou que le gouvernement a déclaré comme étant des « stupéfiants » aux termes de la *Loi*. Aucune distinction n'est faite entre les drogues dures et les drogues douces. Comme on le verra plus loin, la nature de la substance fait cependant partie des critères qui déterminent la gravité d'une infraction. Les stupéfiants sont divisés en cinq listes. La liste I contient les drogues illégales sans usage médical ; les listes II à IV portent sur les stupéfiants à usage médical et dont les importations et les exportations sont réglementées ; la liste V comprend les stupéfiants qui ne sont pas soumis à un contrôle international. Conformément à la loi, les stupéfiants à usage médical ne peuvent être fournis que sur ordonnance d'un médecin, d'un dentiste ou d'un vétérinaire.

Infractions

En Suède, presque toutes les formes d'utilisation de stupéfiants sont interdites conformément à la *Loi sur les stupéfiants*. Cette loi énumère les comportements et les pratiques qui constituent une infraction et qui comprennent la possession pour usage personnel, l'approvisionnement (qui est assez largement défini), la fabrication, etc. Même la consommation (usage de drogue) est interdite depuis 1988. Dans ce cas, [traduction] « *ce n'est pas la dépendance qui est une infraction criminelle selon la Loi, mais l'acte d'ajouter une drogue à l'organisme humain* ».[114] La police est autorisée à soumettre quiconque est soupçonné d'avoir consommé des drogues à des analyses de sang ou d'urine.

La *Loi sur la contrebande de 2000* régit les importations et les exportations illégales de drogues. Les autres lois pertinentes comprennent : la *Loi sur le dopage de 1991* qui réglemente l'importation, l'offre, la possession de substances destinées à augmenter le rendement; la *Loi sur l'interdiction de certaines substances dangereuses pour la santé de 1999* qui régit la possession et l'offre de substances qui nuisent à la vie ou à la santé et qui sont utilisées ou peuvent l'être à des fins intoxicantes – cette loi ne régit pas les substances visées par d'autres lois.

Les autres lois pertinentes sont : la *Loi sur les services sociaux de 1980* qui détermine les formes possibles de soins pour les toxicomanes et la *Loi sur le traitement forcé des toxicomanes* selon laquelle un toxicomane qui est dangereux pour lui-même ou pour les autres peut se voir ordonner par le tribunal de suivre un traitement (qui suppose une privation de liberté pendant une période pouvant aller jusqu'à six mois pour les adultes

[114] Dorn, N., et A. Jamieson, (2001) *European Drug Laws : the Room for Manoeuvre*, London : DrugScope, page 188.

et même plus pour les jeunes de moins de 21 ans). D'autres lois prévoient l'expulsion possible des écoles des étudiants toxicomanes, la révocation du permis de conduire en cas de toxicomanie, etc. La tolérance zéro a été adoptée pour la conduite sous influence de drogue.

Sanctions

Le *Code pénal* suédois prévoit trois niveaux de sanctions pour les infractions liées à la drogue : mineure, ordinaire et grave. Pour les infractions mineures, les sanctions peuvent être des amendes ou un emprisonnement pouvant aller jusqu'à six mois ; pour les infractions ordinaires, jusqu'à trois ans ; et pour les infractions graves, de deux à dix ans d'emprisonnement. Les sanctions assujetties à la *Loi sur la contrebande* sont identiques.

La gravité de l'infraction dépend de la nature et de la quantité de drogues et d'autres circonstances. Le gouvernement a précisé qu'une « infraction mineure liée à la drogue » correspondait au niveau véritablement le plus faible d'infraction. Par exemple, il ne devrait généralement s'agir que de l'usage ou la possession à des fins personnelles de très petites quantités. Dans ce cas, une amende serait justifiée. L'amende est alors basée sur le revenu du contrevenant. Les infractions mineures comprennent : les amphétamines, jusqu'à 6 g, le cannabis, jusqu'à 50 g, la cocaïne, jusqu'à 0,5 g et l'héroïne, jusqu'à 0,39 g; les infractions ordinaires englobent : les amphétamines, de 6,1 à 250 g, le cannabis, de 51 g à 2 kg, la cocaïne, de 0,6 g à 50 g, et l'héroïne, de 0,04 à 25 g, tandis que les infractions graves comprennent : les amphétamines, 250 g ou plus, le cannabis, 2 kg ou plus, la cocaïne, 51 g ou plus, et l'héroïne, 25 g ou plus. Le trafic de stupéfiants mène généralement à l'emprisonnement.

En ce qui concerne la contrebande, afin de déterminer si l'infraction est grave, il faut se demander si elle faisait partie d'une activité accomplie à grande échelle ou à l'échelle commerciale, si elle nécessitait des quantités particulièrement grandes de stupéfiants et si elle était plutôt d'une nature dangereuse.

En 1996, des 5 862 personnes qui ont été condamnées pour des infractions liées à la drogue, 3760 l'ont été pour des infractions mineures, 1 708 pour des infractions ordinaires et 391 pour des infractions graves. Parmi les 1 274 personnes à qui il a été imposé une peine d'emprisonnement, 54 l'ont obtenue pour des infractions mineures, 893 pour des infractions ordinaires et 326 pour des infractions graves.[115]

Comme dans d'autres pays, il existe plusieurs solutions de rechange à l'emprisonnement. Par exemple, le tribunal peut choisir d'autres sanctions, dont la probation, la condamnation avec sursis ou le traitement forcé. Ces sanctions semblent être utilisées fréquemment dans les affaires de stupéfiants.[116]

---

[115] Boekhout van Solinge, *op. cit.*, page 206.
[116] *Ibid.*, page 190.

> [Traduction] « *Généralement, le toxicomane qui est trouvé coupable d'un crime quelconque peut, dans certaines circonstances, se voir ordonner de suivre un traitement de désintoxication. Le traitement peut être jumelé à une sentence d'emprisonnement ou à une ordonnance de probation ou à une sentence d'emprisonnement avec sursis ou alors avec une libération conditionnelle. Le consentement de la personne déclarée coupable à suivre le traitement dans certaines conditions peut constituer une raison d'ordonner la probation plutôt que l'emprisonnement (la fameuse* convention de traitement*). Dans la pratique, la probation et la sentence d'emprisonnement avec sursis associées au traitement forcé sont généralement utilisées pour les infractions de gravité* ordinaire, *c'est-à-dire dans les cas où une peine d'emprisonnement serait autrement imposée.* »[117]

Les lois suédoises permettent aussi la saisie de toute drogue utilisée pour commettre une infraction, de tous les gains réalisés, des biens ayant servi à commettre l'infraction, etc.

Pouvoir discrétionnaire de poursuivre

Le procureur a le devoir absolu de poursuivre, mais il y a un certain nombre d'exceptions à cette règle générale. Dans une Circulaire sur certaines questions concernant le traitement des affaires de stupéfiants, le procureur général a déclaré que l'abandon des poursuites en cas d'infractions liées aux stupéfiants devait être limité aux affaires traitant uniquement de possession pour usage personnel de quantités indivisibles ou correspondant tout au plus à une dose de résine de cannabis ou de certains stimulants du système nerveux central, à l'exception de la cocaïne, c'est-à-dire à une quantité de stupéfiants suffisamment petite pour ne pouvoir être normalement divisée et vendue. Étant donné la difficulté de déterminer les limites de cette quantité, des poursuites devraient être entamées en cas de doute. Si les circonstances sont telles que l'on peut supposer que la possession, malgré la quantité limitée, ne visait pas un usage personnel, la poursuite ne doit pas être abandonnée. Compte tenu de ces remarques, les poursuites ne devraient pas non plus être abandonnées lorsque le toxicomane se trouve en possession de stupéfiants correspondant à un usage personnel pour une certaine période. En outre, il est de grande importance que l'abandon des poursuites soit surtout limité aux cas de première infraction.[118]

Le débat en Suède

La vision suédoise d'une société sans drogue est tellement largement acceptée qu'elle n'est pas remise en question sur la scène politique ou dans les médias. La politique en matière de drogue bénéficie du soutien de tous les partis politiques et, selon les sondages d'opinion, la démarche restrictive obtient un large appui du public. Par exemple, un sondage réalisé en 2001 révèle que 96 % des répondants étaient opposés à la légalisation de toute drogue classée. En outre, un autre sondage effectué

---

[117] *Ibid.*, page 191.

[118] Observatoire européen des drogues et des toxicomanies, *op. cit.*

en 2000 a démontré que 91 % étaient contre la décriminalisation de l'usage du cannabis.[119]

> [Traduction] *« Le rôle de l'opinion publique est essentiel à la compréhension de l'attitude des différents partis politiques. Les sondages d'opinion démontrent qu'une grande partie des gens appuient une politique restrictive en matière de drogue. Les mêmes sondages révèlent que les stupéfiants sont considérés comme l'un des principaux problèmes sociaux. La panique morale entourant les drogues est telle qu'aucun parti politique n'ose parler contre des mesures qui pourraient sembler aller dans le sens d'une libéralisation, aussi minime soit-elle, de la politique en matière de drogue. Appuyer la politique restrictive, ou même réclamer des mesures plus restrictives pour freiner l'intensification du problème des drogues est une attitude essentielle à l'obtention de votes pour un parti politique. Se montrer en faveur du contraire, appuyer une démarche légèrement libérale n'est pas possible pour un parti politique et contribuerait même à signer son arrêt de mort politique. On a signalé que les groupes de pression antidrogue sont les forces motrices qui influent sur l'opinion publique et, par le fait même, sur les partis politiques. On a aussi démontré que, mis à part les mouvements sociaux, les médias ont contribué à accroître la crainte de la drogue qui existe aujourd'hui et à définir les drogues comme un important problème social. »*[120]

Ainsi, la population suédoise en général a une vision négative de l'usage des drogues et est convaincue que celles-ci constituent une importante menace pour la société. Ces thèmes ont été publicisés par le gouvernement, les médias et d'autres organismes de Suède, et il est rare que d'autres groupes les critiquent. Les scientifiques sont généralement les seuls à émettre des doutes quant à la politique actuelle.

Rapports récents

En 1998, le gouvernement a créé une Commission sur les stupéfiants. Celle-ci avait pour mandat d'évaluer la politique suédoise en matière de drogue et de proposer, toujours suivant le concept d'une politique restrictive, des mesures de renforcement et de rationalisation. La Commission ne devait pas dévier de l'objectif général d'une société sans drogue. Son mandat était le suivant :

- Proposer des améliorations aux méthodes et aux systèmes d'évaluation de la situation des drogues et évaluer l'objectif d'une société sans drogue ;
- Évaluer et proposer des mesures visant à renforcer et à rationaliser les mesures de prévention de la toxicomanie ;
- Analyser la mise sur pied des programmes de traitement, y compris ceux du système de probation et d'établissements pénitentiaires, et proposer des mesures visant à améliorer le traitement et la réadaptation des toxicomanes ;

---

119 National Institute of Public Health, *National Report : Sweden 2001*, Stockholm, décembre 2001, page 14.

120 Boekhout van Solinge, *op. cit.*, pages 172-173.

- Évaluer l'étendue et la portée des fonds nationaux pour la mise au point de traitements et de mesures visant à prévenir les crimes liés à la drogue ;
- Analyser la nécessité d'apporter des changements aux méthodes de travail du système judiciaire et aux lois procédurales du droit pénal et du droit criminel;
- Examiner les recherches en cours, proposer des moyens de stimuler la recherche, de la renforcer et de l'organiser ainsi que de définir les champs de recherche importants mais négligés dans le domaine des stupéfiants ; et
- Tracer les grandes lignes des stratégies visant à établir des mesures d'information ciblée et à influencer l'opinion.

La Commission a récemment publié un rapport intitulé *The Crossroads* (le carrefour – faisant référence à une voie qui nécessite une augmentation importante de ressources sous forme d'engagement, d'orientation, de compétences et de financement et à une autre qui suppose une réduction des objectifs et une acceptation considérable de la toxicomanie).

La Commission a noté que la question des drogues ne figurait pas parmi les priorités politiques des dernières années, ce qui avait mené à une réduction des fonds pour tous les secteurs en cause, tandis que le problème des drogues devenait de plus en plus grave et étendu. Les paragraphes qui suivent résument quelques-unes des conclusions et des recommandations principales de la Commission.[121]

Leadership : La Commission a noté qu'il fallait fixer plus clairement les priorités, répartir plus clairement les tâches et assurer un meilleur suivi de la politique en matière de drogue et des initiatives concrètes à tous les niveaux de gouvernement.

Réduction de la demande : La Commission a noté qu'il n'y avait pas de limites précises entre les volets des mesures de prévention, des soins et de la désintoxication et la restriction de l'offre. Pour que les mesures préventives donnent des résultats positifs, elles doivent [traduction] «*faire partie d'un système de mesures restreignant l'offre et il doit exister des règles claires englobant les normes et les valeurs de la société, ainsi que des soins et des traitements efficaces*».[122] De même, la Commission considère les soins et le traitement comme un élément essentiel des mesures de la politique en matière de drogue, puisqu'ils aident à réduire la toxicomanie de même que les conséquences négatives pour les toxicomanes. En outre, la Commission a déterminé la nécessité d'améliorer la compétence de ceux qui travaillent dans le domaine des soins et du traitement. Elle a établi les principes directeurs suivants concernant les soins et le traitement :

- Tous les toxicomanes doivent bénéficier d'une offre d'aide et, au besoin, de soins pour leur problème de toxicomanie.

---

[121] The Swedish Commission on Narcotic Drugs, (2000) *Summary of the report The Crossroads from the Swedish Commission of Narcotic Drugs*, Suède.

[122] *Ibid.*

- Des conseils, de l'aide et un appui doivent être offerts dès les premiers stades de consommation.
- Les soins doivent viser à l'objectif d'une vie sans toxicomanie et sans drogues illégales.
- Les soins et d'autres mesures visant les toxicomanes doivent être de bonne qualité.
- Les mesures visant à combattre la toxicomanie doivent être durables et appliquées à long terme.

Réduction de l'approvisionnement : La Commission n'a pas trouvé de lacunes réelles dans la loi ou dans les méthodes de travail utilisées par les autorités, bien qu'elle ait jugé impératif que ces autorités obtiennent davantage de ressources. Les services de police et de douanes n'ont pas réussi à éliminer le marché clandestin. En fait, tout semble indiquer que l'offre est encore plus généreuse, que les prix sont plus bas que par le passé et que la variété des drogues a augmenté. En ce qui concerne la lutte au marché des drogues illicites, la Commission a recommandé d'examiner la structure organisationnelle de la police (par exemple, la façon dont la dissolution des brigades de stupéfiants spécialisées a nui à la qualité des enquêtes policières) et d'assurer le suivi de toutes les faiblesses observées. La Commission a aussi recommandé d'examiner les méthodes d'enquête spéciales (comme les livraisons contrôlées) et de rédiger des lignes directrices sur le sujet à partir des conclusions de l'examen.

Perfectionnement des compétences et recherche : La Commission était d'avis qu'il était important d'améliorer les connaissances sur différents aspects des stupéfiants, les mesures utilisées pour lutter contre la toxicomanie et l'effet de la politique en matière de drogue.

Coûts[123]

Comme dans d'autres pays, il n'existe pas de données statistiques systématiques sur les coûts liés aux stupéfiants qui soient facilement accessibles.

Coûts publics

Le coût du traitement de la toxicomanie (alcool et stupéfiants) a été estimé pour les municipalités à 3,7 milliards SEK (plus de 500 millions $ canadiens) par année (55 % pour les soins en établissement). La police a utilisé 6 % de son budget pour la lutte antidrogue en 2000 (pour un total de 702 millions SEK – plus de 100 millions $ canadiens). Au sein des services de police, 869 personnes travaillaient à des questions relatives aux stupéfiants, tandis que dans les services douaniers, 1 080 personnes étaient

---

[123] L'information qui suit découle de : OEDT, *National Report – Sweden 2001*, *op. cit.*, page 15.

affectées à la protection des frontières. Aucune donnée sur les coûts n'est disponible pour les douanes.

Coûts sociaux

La Commission sur les stupéfiants estime les coûts sociaux à 7,7 milliards SEK par année (ce total ne tient pas compte de la prévention, de la formation et de l'évaluation).

Administration[124]

Comme nous l'avons mentionné antérieurement, un coordonnateur est maintenant en charge de la politique nationale en matière de drogue. Par le passé, ce rôle était rempli par le ministère de la Santé et des Affaires sociales. En ce qui concerne la distribution licite des stupéfiants et des substances psychotropes, l'Agence des produits médicaux s'occupe d'émettre les autorisations d'importation et d'exportation de drogues. Cette Agence fournit aussi des statistiques sur les drogues au PNUCID.

La police nationale suédoise est chargée de la lutte antidrogues. La Division des infractions en matière de drogue du Conseil national de police procède aux enquêtes criminelles reliées au crime organisé ou à toute autre infraction liée à la drogue à l'échelle nationale ou internationale. Le Service des douanes suédois s'occupe des points d'entrée.

L'Institut national de santé publique coordonne les activités de réduction de la demande. Il est également le point de liaison national du réseau REITOX. Les activités opérationnelles sont coordonnées aux niveaux régional et municipal. C'est aussi le point de coordination avec les services sociaux, les services de police, les services de probation et de détention, les services médicaux, les écoles et toutes les autres parties en cause. Ainsi, pour ce qui est de la prévention, des soins et du traitement, les groupes locaux et municipaux ont un rôle clé à jouer.

À cause de sa nature globale, le problème de la drogue met en jeu d'autres ministères, par exemple le ministère de la Justice et le ministère des Affaires étrangères.

Statistiques

Consommation[125]

Les enquêtes effectuées auprès des jeunes de 9e année (15 ans) et des jeunes conscrits de 18 ans, révèlent une tendance évidente, au cours des années 1990, à l'augmentation de la consommation de drogues au cours de la vie parmi les adolescents, particulièrement les plus âgés. On a aussi observé une augmentation de l'usage récent

---

[124] L'information fournie dans cette section provient de : United Nations Office for Drug Control and Crime Prevention, *Country Drug Profile – Sweden*, *op. cit.*, page 12

[125] OEDT, National Report – Sweden 2001, *op. cit.*

(année dernière, 30 derniers jours) parmi les adolescents et les jeunes adultes. Le pourcentage de jeunes de 15 ans qui déclarent avoir déjà essayé des drogues est passé de 4 % à 9 % de 1992 à 2000. Il est intéressant de noter que ce nombre était de 14 % au début des années 1970 et qu'il avait diminué à environ 8% en 1982. En ce qui concerne les jeunes conscrits, la tendance est à peu près la même. Selon ces enquêtes, la consommation de drogues illicites est faible comparativement à celle d'autres pays européens. Il faut noter que ces données ont été critiquées. Premièrement, elles s'appliquent seulement aux jeunes étudiants de 15 et 16 ans et aux jeunes conscrits de 18 ans, ne tenant pas compte des groupes plus âgés où il y aura première expérimentation. En outre, certains doutent de la fiabilité des déclarations de consommation par les élèves, dans un contexte où les drogues sont perçues de façon aussi négative et où les questionnaires sont remplis à l'école (où certains peuvent craindre d'être observés par leurs enseignants).[126]

En 2000, la moyenne mobile de trois ans de consommation au cours de la vie pour le groupe des 15 à 64 ans était de 12 % (la plus élevée étant de 17 % pour le groupe des 24 à 44 ans). Depuis 1988, la consommation récente, pour les douze derniers mois, n'a jamais dépassé 1 %. Dans l'ensemble, les hommes sont deux fois plus susceptibles d'avoir consommé des drogues que les femmes, bien que la différence ne soit pas aussi élevée chez les groupes plus jeunes.

La plupart de ceux qui ont consommé des drogues ont essayé le cannabis et une grande partie de ceux-là ont seulement essayé le cannabis (en Suède, le cannabis est habituellement pris sous forme de haschisch). La deuxième catégorie de drogues la plus populaire en Suède est le groupe des amphétamines. La cocaïne serait la troisième plus répandue chez les plus âgés, tandis que chez les jeunes, ce serait le MDMA (*ecstasy*) et le LSD. Pendant les années 1990, la disponibilité des drogues a augmenté, en particulier les amphétamines et l'héroïne. Il semble cependant que l'usage d'héroïne soit en hausse.

Généralement, les sondages révèlent que les drogues en général sont assez peu utilisées en Suède. Pour ce qui est des toxicomanes (définis comme faisant usage d'intraveineuses ou une consommation quotidienne de drogues), il semble que la Suède ait un problème assez grave, avec un éventail de 14 000 à 20 000 personnes, ce qui est proche de la moyenne de l'Union européenne.[127]

Infractions

Le nombre de personnes incriminées a augmenté, passant de 6567 en 1985 à 12 470 en 1999. La police a enregistré 32 423 infractions à la *Loi sur les stupéfiants* en 2000, ce qui est comparable aux données de la dernière décennie. Le nombre d'infractions à la *Loi sur la contrebande* a diminué de 85 % depuis 1980, baissant à 350.

---

[126] Boekhout van Solinge, *op. cit.*, page 138.

[127] United Nations Office for Drug Control and Crime Prevention, *op. cit.*, page 9.

En 1998, 92 % ont été soupçonnés d'usage ou de possession (par rapport à 76 % en 1975). En outre, le nombre de ceux qui sont soupçonnés de vendre ou de fabriquer des drogues est maintenant de 19 % (par rapport à 40 % en 1975).

Le nombre de sentences rendues pour infractions à la *Loi sur les stupéfiants* ou à la *Loi sur la contrebande* est maintenant de 12 470 pour 1999 (par rapport à 2 601 en 1975). Le cannabis était en cause dans 51 % des sentences en 1998. La même année, le genre de sentences était réparti de la façon suivante : 38 %, amendes ; 27 %, emprisonnement; 14 %, abandon de poursuites; 14 %, probation; et 8 %, autres sanctions. L'emprisonnement était généralement d'une durée de deux à six mois.[128]

[128] National Report 2001, page 27.

LA SUISSE[129]

La Suisse a beaucoup fait parler d'elle ces dernières années en matière de politique sur les drogues : après les images hautement médiatisées sur la scène ouverte de Zurich, les cliniques d'injection et la prescription d'héroïne aux toxicodépendants ont fait le tour du monde ; plus récemment, le Parlement fédéral a déposé un projet de réglementation de la production et de la vente de cannabis qui est actuellement à l'étude.

La Suisse est une Confédération[130] composée de 26 entités cantonales (cantons et demi-cantons) qui compte un peu plus de 7 millions d'habitants. Les cantons sont actuellement subdivisés en 2 904 communes politiques. La Constitution fédérale, adoptée en 1848, est le fondement juridique de l'État fédératif. Elle garantit les droits fondamentaux des individus et la participation du peuple à la vie politique, répartit les tâches entre la Confédération et les cantons et définit les attributions des autorités fédérales. La Suisse regroupe différentes communautés linguistiques, ethniques et confessionnelles. Selon l'article 4 de la Constitution, l'allemand, le français, l'italien et le romanche sont les quatre langues nationales. L'allemand est la langue parlée par la majorité des Suisses (63,7 %). Tous les cantons ont leur propre constitution, ainsi que leurs parlement, gouvernement et tribunaux. Les cantons ont certaines compétences législatives que leur confère la Constitution fédérale.

Cette structure politique de la Suisse est importante pour notre compréhension de la politique de ce pays en matière de drogue. En fait, certains auteurs[131] arguent qu'il y a en fait 26 politiques en matière de drogue en Suisse, une pour chaque canton et demi-canton. Cette diversité cantonale est parfois occultée puisque les médias et la littérature portent un intérêt particulier aux « scènes ouvertes » à Zurich et à la prescription médicale d'héroïne chez les personnes gravement dépendantes, pratique entérinée par la Confédération suisse.[132]

Une politique de réduction des risques

L'histoire récente de la politique suisse en matière de drogue débute vers la fin des années 1960 avec une hausse marquée de la consommation de substances psychoactives. Un premier modèle, fondé sur trois piliers, a alors été élaboré et mis en œuvre par les cantons. Les trois piliers étaient les suivants :

---

129 Cette section s'inspire notamment du rapport d'étude préparé par la Bibliothèque du Parlement à la demande du Comité : Collin, C., (2002) *Politique nationale en matière de drogues : la Suisse.* Ottawa : Bibliothèque du Parlement, rapport préparé pour le Comité spécial du Sénat sur les drogues illicites. Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp

130 Ce terme désigne l'état fédéral.

131 Boggio, Y. et coll., (1997) *Apprendre à gérer : La politique suisse en matière de drogue*, Genève : Georg.

132 *Ibid.*, page 38.

- La répression du trafic et de la consommation de drogue ;
- Des mesures de prévention auprès des jeunes ; et
- La thérapie axée sur l'abstinence, dont les programmes avec la méthadone faisaient déjà partie.[133]

Au début des années 1980, la Suisse a été touchée, comme plusieurs autres pays, par l'épidémie du VIH/sida. Des « scènes ouvertes » de la drogue existaient dans certaines villes suisses : Zurich, Berne, Olten et Soleure, rendant plus visible la misère des toxicomanes et contribuant à l'insécurité des populations. Des services publics et sociaux ont été mis en place pour aider les toxicomanes et les protéger du VIH et du sida. Des seringues stériles étaient distribuées aux toxicomanes et on les encourageait à recevoir le vaccin contre l'hépatite. L'Office fédéral de la santé publique (OFSP) soutenait et soutient toujours plusieurs de ces services, justifiant son soutien par la nécessité de prévenir la propagation du sida. Cependant, les grands piliers de la politique officielle demeuraient la prévention, la thérapie et la répression.

Les années 1990 ont vu l'introduction de mesures visant à réduire les problèmes de drogue et l'adoption d'une nouvelle stratégie à l'échelle nationale, à laquelle est venu s'ajouter le pilier de la réduction des risques pour créer le modèle des quatre piliers. Le rôle de la Confédération en matière de drogue se précise alors de plus en plus : soutenir les efforts des cantons, des villes et communes et des organisations privées en leur offrant des informations de référence et des connaissances scientifiques et en développant le savoir-faire des professionnels.

Le 20 février 1991, le gouvernement suisse a adopté un programme de mesures fédérales pour réduire les problèmes de la drogue[134]; aujourd'hui connu sous le nom de « ProMeDro »[135], ce programme s'inspirait du concept de la réduction des risques. Il avait pour objectifs :

- Diminuer l'entrée dans la consommation de drogue et d'éviter l'évolution vers une dépendance ;
- Améliorer les possibilités de sortie de la toxicomanie (thérapie et réintégration) ; et

---

[133] Office fédéral de la santé publique, *La politique en matière de drogue*, septembre 2000, disponible en ligne à l'adresse http://www.bag.admin.ch/sucht/f/index.htm.

[134] Office fédéral de la santé publique, *Mesures fédérales pour réduire les problèmes de la drogue*, Document de base de l'Office fédéral de la santé publique, Décision du Conseil fédéral du 20 février 1991, Doc. no 3.4.1f.

[135] L'acronyme « MaPaDro » était utilisé en référence au programme de mesures fédérales au cours de la période 1990-1996. L'acronyme «ProMeDro» est utilisé en référence au programme de mesures fédérales pour la période 1997-2002. Afin d'éviter toute confusion, «ProMeDro » est utilisé tout au long du présent document.

- Améliorer les conditions de vie et de santé des usagers de drogues, de réduire les risques et de maintenir leur intégration sociale[136].

Pour ce faire, on prévoyait :

- Des mesures de prévention primaire et secondaire auprès des jeunes et des campagnes de sensibilisation, afin d'éviter que de nouvelles personnes commencent à consommer de la drogue ;
- La prise en charge et la thérapie, afin de faciliter la sortie de la drogue ;
- Des mesures de réduction des risques, de prévention du sida et d'aide à la réinsertion, afin de permettre aux personnes dépendantes de traverser leur phase de toxicomanie dans les conditions de santé les moins mauvaises possibles et de veiller à ce que le chemin de la sortie de la drogue reste ouvert ;
- Des mesures de formation continue et de perfectionnement à l'intention des professionnels (p. ex. exécution des peines et mesures, hôpitaux, pharmacies, médecins de famille, services sociaux, etc.) et des personnes exerçant une fonction de médiateurs (p. ex. enseignants, animateurs de groupes de jeunes, personnel d'entreprises, parents, etc.) ;
- Le développement, la coordination et la systématisation de la recherche scientifique dans le domaine de la drogue ;
- L'évaluation des projets et des mesures dans les domaines de la prévention, de la prise en charge et du traitement, afin de préciser les lacunes et les insuffisances, mais aussi de mettre en évidence les effets positifs de ces interventions ;
- Le développement des prestations de services de documentation et d'information habituellement fournies par la Confédération ; et
- La coordination des mesures prises par la Confédération.

Ces mesures marquent l'introduction en Suisse de la politique des quatre piliers, qui englobe la prévention, la répression, la thérapie et la réduction des risques. Entre 1991 et 1999, l'OFSP a lancé ou, du moins, appuyé environ 300 projets et programmes dans le cadre de « ProMeDro » pour des montants annuels de 15 millions de francs.

Entre autres, le Conseil fédéral a commandé une étude concernant la prescription médicale d'héroïne aux toxicomanes souffrant d'une grave dépendance à cette drogue et pour lesquels d'autres formes de traitement n'avaient pas eu de succès. En 1992, le Conseil a adopté une ordonnance autorisant des essais cliniques de prescription médicale d'héroïne et demandant une stricte évaluation scientifique de ces essais. Ces

---

[136] Office fédéral de la santé publique, Programme de mesures de santé publique de la Confédération en vue de réduire les problèmes de drogue (ProMeDro) 1998-2002, octobre 1998.

essais ont débuté en 1994 et pris fin le 31 décembre 1996. Un rapport final d'évaluation, publié en juillet 1997, conclut que :

- Le traitement avec prescription d'héroïne suivi par des personnes gravement dépendantes de cette substance avait eu un impact positif sur la santé physique ou psychique, ou les deux, et sur la qualité de vie (logement, travail, etc.) des participants ;
- Leur consommation illégale d'héroïne et de cocaïne avait reculé ; et
- Les participants avaient diminué leurs activités criminelles (très importante diminution des vols et délits contre la propriété et du trafic de stupéfiants).[137]

Suivant les recommandations du rapport, le Conseil fédéral suisse a adopté le 8 mars 1999, *l'Ordonnance sur la prescription médicale d'héroïne* qui autorisait le traitement avec prescription d'héroïne et définissait les objectifs, les critères d'admission, l'administration et l'institution d'un tel traitement.

Au cours de la même période, deux initiatives populaires adoptant des positions complètement opposées ont été proposées en 1993 et 1994. La première suggérait l'adoption d'une politique en matière de drogue exclusivement axée sur l'abstinence (Jeunesse sans drogue[138]) et la deuxième proposait la légalisation des stupéfiants (DroLeg[139]). Le gouvernement fédéral et le Parlement ont considéré ces deux initiatives populaires extrémistes et recommandé à la population suisse de les rejeter. Le 28 septembre 1997, les citoyens suisses ont voté contre « Jeunesse sans drogue » dans une majorité de plus 70 %. De même, le 29 novembre 1998, une majorité de plus de 74 % des votants a rejeté l'initiative DroLeg. En rejetant ces deux initiatives, la population suisse entérinait en quelque sorte l'approche plus mesurée suivie par la Confédération.

Entre le lancement de ces initiatives populaires et leur refus par vote populaire, certains événements importants ont aussi influencé l'évolution de la politique suisse en matière de drogue. En 1994, la violence sur les « scènes ouvertes de la drogue », entre autres du Letten à Zurich, fit la une des médias de par le monde. Certains partis gouvernementaux (socialiste, démocrate-chrétien et radical) ont alors demandé une dépénalisation de l'usage de drogue, l'accroissement du traitement avec prescription d'héroïne, le renforcement des mesures de prévention et le durcissement des peines à l'égard de ceux qui font le trafic de stupéfiants.[140] La scène ouverte de la drogue à

---

[137] Aebi, M.F., Killias, M. et D. Ribeau, (1999) « Prescription médicale de stupéfiants et délinquance : Résultats des essais suisses », *Criminologie*, vol. 32, nº 2, p. 127-148; voir aussi le témoignage du professeur Ambros Uchtenhagen, Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 4 février 2002, fascicule 13.

[138] Pour plus d'information sur cette initiative, voir le site Web de Jeunesse sans drogue à l'adresse http://www.jod.ch/f_fr_index.htm.

[139] Pour plus d'information sur cette initiative, voir le site Web de DroLeg à l'adresse www.droleg.ch.

[140] Office fédéral de la santé publique (2000), *op.cit*, p. 10.

Zurich a été fermée en 1995.[141] Cette fermeture a amené la naissance d'une nouvelle collaboration entre le Conseil fédéral, les représentants du canton et de la ville de Zurich. Un groupe de travail mixte a été formé : la Délégation drogue. Cette collaboration inhabituelle a permis la mise en place de mesures qui n'auraient pas vu le jour dans un contexte plus traditionnel : la création de places de prison à Zurich pour les trafiquants de drogue, l'adoption de mesures fédérales urgentes afin d'accroître la possibilité pour les toxicomanes de participer à un programme de prescription médicale d'héroïne et la création de centres d'accueil pour recevoir et accompagner les personnes les plus gravement dépendantes.[142] Les scènes ouvertes de drogue appartiennent aujourd'hui au passé.

Enfin, en octobre 1998, le Programme de mesures de santé publique en vue de réduire les problèmes de drogue (ProMeDro) a été reconduit pour une période de quatre ans. La Confédération a alloué un budget de 18 millions de francs par année afin de réaliser ce programme, à quoi s'ajoutent 15 postes de collaborateurs de l'Office fédéral de la santé publique.[143] Les principales priorités de ProMeDro pour la période 1998-2002 sont les suivantes :

- Accroître l'engagement de la Confédération en matière de prévention primaire et secondaire et d'intervention précoce pour éviter une évolution vers la toxicomanie;
- Consolider l'offre de thérapies en tant que système coordonné, assurant mieux les possibilités pour une sortie de la dépendance;
- Consolider l'offre de mesures de réduction des risques et de maintien de l'intégration sociale;
- Installation et fonctionnement efficace d'un observatoire de « monitoring épidémiologique » national sur le modèle des « focal points REITOX » de l'Observatoire européen des drogues et des toxicomanies[144]
- Transmission effective des résultats des études épidémiologiques, des recherches scientifiques et des évaluations en matière de toxicomanie à l'intention des spécialistes et des décideurs;
- Installation d'un processus de promotion et de gestion de la qualité, commun à l'ensemble de ProMeDro, adapté selon les domaines, utile à plus de la moitié des institutions du domaine de la toxicomanie et des

---

[141] Voir le témoignage du Chef de la police criminelle de Zurick, Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 4 février 2002, fascicule 13.

[142] Boggio, et coll., (1997) *op. cit.*, page 75-80.

[143] OFSP (1998) *op. cit.*, page 5.

[144] L'OEDT coordonne un réseau de 15 centres d'information, ou points focaux nationaux, situés dans chacun des États membres. Pour plus d'information voir le site Web de l'OEDT à l'adresse http://www.emcdda.org/mlp/ms_fr-4.shtml.

décideurs concernés et utilisé par ces institutions et décideurs (Confédération, cantons, communes, institutions privées);

- Optimiser le fonctionnement coordonné et opérationnel des diverses commissions et plates-formes, principalement de la Conférence des Délégués cantonaux aux problèmes de Toxicomanie et du Comité national de liaison en matière de drogue.[145 ; 146]

La Confédération confirmait ainsi son rôle de plaque tournante de la politique en matière de drogue et de la collaboration à l'échelle nationale.

Premier pilier : la prévention

Les mesures de prévention visent principalement trois objectifs :

- Éviter que les individus, en particulier les enfants et les jeunes, consomment de la drogue;
- Éviter que les problèmes et les effets néfastes liés à la consommation de drogue se répercutent sur l'individu et la société;
- Éviter que les individus passent de la simple consommation de drogue à une consommation abusive et à la dépendance, avec les graves conséquences que l'on sait.

Il faut souligner que le changement le plus notable dans le domaine de la prévention est le passage d'une conception de la prévention visant à empêcher la première consommation de drogue à une conception qui cible plutôt la prévention des problèmes sanitaires et sociaux liés à la consommation de drogue et qui intègre le réseau social et l'environnement de la personne.

Deuxième pilier : la thérapie

En Suisse, plusieurs formes de traitements résidentiels et ambulatoires sont disponibles aux personnes qui ont un problème de dépendance à la drogue. Les objectifs poursuivis par le traitement incluent :

- Sortir les toxicomanes de la dépendance ;
- Oeuvrer à leur réinsertion sociale ; et
- Améliorer leur santé physique et mentale.[147]

---

[145] La Conférence des délégués cantonaux se réunit en général quatre fois par an. Elle coordonne des mesures relevant du domaine des toxicomanies, établit un programme annuel et catalogue des priorités ; vise à l'échange d'informations; débat et adopte des prises de position et répond aux consultations ; définit et discute des questions connexes ; et offre des sessions de perfectionnement. Voir http://www.infoset.ch/inst/kkbs/f-statuten.html. Le comité national est formé de représentants des autorités des villes, des cantons et de la Confédération. Son rôle est d'assurer le suivi des mesures mises en œuvre et veiller à leur harmonisation.

[146] OFSP (1998) *op. cit.*, pages 6-7.

[147] *Ibid.*, page 16.

Comme il a été mentionné plus tôt, le traitement avec prescription d'héroïne est une forme reconnue de thérapie en Suisse depuis 1999. À la fin de 1999, on comptait déjà 1 650 places réservées aux personnes gravement dépendantes de l'héroïne, réparties dans 16 centres de traitement. De plus, à la même période, environ 50 % des personnes dépendantes des opiacés (population estimée à 30 000 personnes) suivaient un traitement avec prescription de méthadone, comparativement à 728 personnes qui suivaient un tel traitement en 1979. Les personnes dépendantes d'une ou de plusieurs drogues ont également accès à des thérapies résidentielles axées sur l'abstinence, à un nombre limité de places dans des centres de transition, des unités ou cliniques spécialisées de sevrage et au sein d'institutions thérapeutiques, ainsi qu'à des centres de consultations ambulatoires.[148] En mars 1999, on comptait 100 institutions offrant des thérapies résidentielles axées sur le sevrage et la réhabilitation en Suisse, pour un total de 1 750 places.[149]

Troisième pilier : la réduction des risques

Les premières institutions, dites «à bas seuil», d'aide à la survie ont fait leur apparition en Suisse dès le milieu des années 1980 et avaient pour but de réduire les risques et les conséquences qu'entraîne la dépendance au niveau sanitaire et social. Ces institutions offraient d'abord un toit au toxicomane et étaient souvent dotées d'une cafétéria, de salles de douches et d'une buanderie. La personne dépendante pouvait aussi y trouver une oreille attentive et un interlocuteur pour dialoguer. Ces mesures d'aide à la survie ont évolué depuis une dizaine d'années et englobent aujourd'hui les appuis médicaux à la réduction des risques (p. ex. prévention du sida et d'autres infections, distributeurs de seringues, dispensaires de soins médicaux ambulatoires, etc.) et les appuis sociaux (travail de rue, soupes populaires, centres d'hébergement d'urgence, centre d'accueil à bas seuil, etc.). L'Office fédéral de la santé publique soutient de nombreux projets de réduction des risques dans le cadre de ProMeDro. Entre autres :

- La distribution de seringues aux toxicomanes et en milieu carcéral ;
- Des locaux d'injection (un avis de droit établit leur légalité) ;
- Des offres d'emploi et de logement ;
- Des services à l'intention des femmes qui se prostituent pour se procurer de la drogue ; et
- Des services de consultation pour les enfants de parents toxicomanes.[150]

Par ailleurs, les cantons, les communes et les institutions privées offrent également de telles mesures. L'OFSP a aussi créé en 1995 un service central chargé de

---

[148] *Ibid.*, pages 16-17.

[149] Office fédéral de la santé publique (1999) *The Swiss drug policy: A fourfold approach with special consideration of the medical prescription of narcotics*, p. 7.

[150] Boggio et coll, (1997) *op. cit.*, page 19.

soutenir certaines institutions d'aide sociale, notamment celles à bas seuil, et de conseiller les cantons, les communes et les institutions privées en matière de planification et de financement de mesures visant la réduction des risques. Les toxicomanes ont accès à ces mesures sans avoir à remplir de conditions particulières. Le but de ces services, dits de réduction des risques, est de faire en sorte que le toxicomane subisse le moins de conséquences possibles liées à sa consommation et de lui permettre de reprendre une existence normale. En outre, ces mesures visent à préserver les chances de sortie de la drogue, voire de les augmenter.[151]

Quatrième pilier : la répression

La répression vise principalement à réduire l'offre et à lutter contre le trafic de stupéfiants, les opérations financières illégales liées à ce trafic (p. ex. blanchiment d'argent) et le crime organisé. Les consommateurs ne sont pas la cible prioritaire des opérations policières en Suisse. L'application de la *Loi fédérale sur les stupéfiants* relève en grande partie de la compétence des cantons, même si la Confédération exerce la haute surveillance et peut ordonner et mener des enquêtes policières en matière de trafic de drogue. Il faut noter que les lois cantonales et communales en matière d'exercice des fonctions des forces de l'ordre diffèrent et donnent parfois lieu à des interventions dépareillées. Par ailleurs, le milieu des drogues évolue rapidement et les méthodes de lutte contre les problèmes liés à la drogue s'améliorent et s'adaptent à ce milieu.[152] Parmi ces méthodes, on trouve :

- La concentration de la répression sur la production de drogue, le trafic et le blanchiment d'argent;
- Un plus grand nombre de «policiers de la drogue » et un plus grand recours à des spécialistes d'autres secteurs (professionnels de la finance);
- La collaboration intercantonale et internationale (accords avec les polices des pays limitrophes);
- L'accélération et l'amélioration du traitement de l'information (systèmes en réseau et accès à des réseaux des corps policiers de plusieurs pays d'Europe);
- L'intensification de la collaboration entre les services de police et le secteur privé (banques, industries chimiques, etc.);
- L'amélioration de l'efficacité de la police et le recours accru à des fonctionnaires de liaison sur le terrain;
- Le renforcement du dispositif légal (p. ex. lois sur la police, protection des témoins).[153]

---

[151] *Ibid.*, pages 18-19.

[152] *Ibid.*, pages 20-21.

[153] *Ibid.*, page 21.

Évolution du régime juridique

L'histoire des mesures législatives régissant les stupéfiants en Suisse, comme dans bien d'autres pays, s'aligne en grande partie sur l'évolution des conventions internationales. Par exemple, la *Loi sur les stupéfiants* de 1924 avait été adoptée pour répondre aux engagements que la Suisse avait pris en signant la Convention internationale de l'opium de 1912. Cette loi interdisait certains stupéfiants tels que l'opium, les feuilles de coca, la morphine, l'héroïne, la cocaïne et leurs dérivés. L'adhésion de la Suisse à d'autres conventions et l'expérience tirée de l'application de la loi de 1924 mena à une révision totale et à l'adoption de la *Loi fédérale sur les stupéfiants* (LStup) du 3 octobre 1951. Cette loi interdisait la culture, la fabrication, la vente, la distribution et la détention d'opiacés, de produits dérivés du coca et du cannabis. Elle avait pour objectif, d'une part, de réglementer l'utilisation de stupéfiants à des fins médicales et, d'autre part, de lutter contre l'abus et le trafic illicite de stupéfiants. La LStup fut légèrement modifiée en 1970 suite à l'adhésion de la Suisse à la Convention unique sur les stupéfiants de 1961.

En fait jusqu'aux années 1960, la *Loi* répondait principalement aux engagements de la Suisse par rapport aux conventions internationales, car la consommation de stupéfiants était relativement marginale et il n'y avait à proprement parler aucun problème d'abus de stupéfiants qui pouvait justifier le besoin d'une loi spécialisée. Par ailleurs, le Conseil fédéral avait reconnu dès 1951 que la toxicodépendance était une pathologie grave qui ne devrait pas donner lieu à des poursuites au titre de crime ou d'infraction. Avec l'apparition de problèmes liés à la drogue au début des années 1970, le législateur a révisé la *Loi* en 1975 de manière à permettre l'application de mesures médico-sociales et d'assistance aux personnes dépendantes de stupéfiants, une pénalisation adaptée de la consommation et le renforcement des dispositions pénales contre le trafic illicite de stupéfiants.[154]

Par suite de l'adhésion de la Suisse à la Convention des Nations Unies sur les substances psychotropes de 1971, à la modification de la Convention unique de 1972 et de la mise en place de la Convention internationale de 1988 contre le trafic illicite de stupéfiants et substances psychotropes (cette convention n'a pas encore été ratifiée par la Suisse), le législateur a révisé la LStup en 1996. Le contrôle des précurseurs – c'est-à-dire des substances servant à la fabrication de stupéfiants – était désormais prévu par la loi. Sont depuis considérés comme stupéfiants au sens de la LStup «les substances et les préparations ayant des effets du type morphinique, cocaïnique et cannabique et qui engendrent la dépendance (toxicomanie) » (LStup, art. 1).[155] La liste des substances est aujourd'hui établie par l'Institut suisse des produits thérapeutiques.[156]

En ce qui a trait à la fabrication, à la distribution, à l'acquisition et à l'utilisation des stupéfiants, la loi actuelle prévoit que les stupéfiants et substances psychotropes ne

---

[154] Conseil fédéral suisse, Message concernant la révision de la loi sur les stupéfiants du 9 mars 2001.

[155] *Loi fédérale sur les stupéfiants et les substances psychotropes* du 3 octobre 1951. (État le 27 novembre 2001) disponible en ligne à l'adresse http://www.admin.ch/ch/f/rs/812_121/index.html#fn1

[156] Nouvelle dénomination sur les produits thérapeutiques, en vigueur depuis le 1er janvier 2002.

peuvent être cultivés, fabriqués, préparés ou commercialisés sans l'autorisation des cantons, selon les conditions arrêtées par le Conseil fédéral (LStup, art. 4). Par ailleurs, « un permis spécial de l'Office fédéral de la santé publique est requis pour toute importation et exportation de stupéfiants soumis au contrôle » (LStup, art. 5). De plus, selon l'article 8 de la LStup, certains stupéfiants « ne peuvent être ni cultivés, ni importés, ni fabriqués ou mis dans le commerce ». Il s'agit de l'opium à fumer, de l'héroïne, des hallucinogènes (tels que le LSD) et du chanvre en vue d'en extraire des stupéfiants et le hachisch. L'article 8 prévoit également les conditions régissant le traitement des personnes toxicodépendantes au moyen de certains stupéfiants.

La loi actuelle prévoit aussi certaines dispositions pénales pour celui, qui sans droit, cultive, fabrique, extrait, transforme ou prépare des stupéfiants et celui; en dehors des cas autorisés, entrepose, expédie, transporte, importe, exporte, offre, distribue, vend, etc., ou achète, détient, possède ou acquiert d'une autre manière des stupéfiants, ainsi que pour celui qui finance un trafic illicite de stupéfiants, sert d'intermédiaire ou provoque à la consommation (LStup, art. 19). Les contrevenants à l'article 19 sont passibles d'emprisonnement ou d'une amende selon la gravité de l'acte commis, telle que définie par la LStup. La consommation intentionnelle de stupéfiants ou la commission d'une infraction à l'article 19 pour assurer sa propre consommation est passible des arrêts ou de l'amende (LStup, art. 19a). Dans les cas bénins, l'autorité compétente peut suspendre la procédure ou renoncer à infliger une peine; une réprimande peut être prononcée (LStup, art. 19a 2). Cependant, la préparation de stupéfiants pour sa propre consommation ou afin d'en partager la consommation avec des tiers sans aucun frais n'est pas punissable lorsqu'il est question de quantités minimes (LStup, art. 19b). Enfin, celui qui décide ou tente de décider une personne à consommer des stupéfiants est également passible des arrêts et de l'amende (LStup, art. 19c).

Un projet de dépénalisation du cannabis[157]

Le Conseil fédéral suisse a récemment soumis à l'attention du Parlement, des cantons et de la population un important projet de révision fondamentale de la LStup. Ce projet, qui doit passer les diverses étapes des consultations cantonales et nationales, repose sur le constat, qui rejoint nos propres conclusions :

> *« (…) en ce qui concerne le cannabis, l'abîme est grand entre la réalité vécue, les dispositions légales et leur application. Comme la Commission fédérale pour les questions reliées à la drogue l'indique dans son rapport sur le cannabis, le régime d'interdiction n'empêche pas la consommation de cannabis et les consommateurs de cannabis ont tendance à ne plus se considérer comme des consommateurs de drogues. Les risques que présente le cannabis pour la santé publique doivent être appréciés autrement que le législateur ne l'a fait en 1975.*
> *À l'époque, le cannabis était considéré comme une drogue d'entrée dans la toxicomanie. On pensait que les propriétés pharmacologiques du cannabis avaient pour caractéristique de pousser les jeunes consommateurs de cannabis vers la consommation d'opiacés ou d'amphétamines. Cette conception a été réfutée dès le rapport de 1989 de la sous-commission de la Commission fédérale des stupéfiants.*
> *Les recherches les plus récentes confortent les résultats obtenus jusqu'ici, selon lesquels les effets du cannabis sont moins dangereux pour la santé que les effets liés à l'alcoolisme ou au tabagisme. (…)*
> *(…)*
> *Le nombre des consommateurs des dérivés du cannabis a augmenté. En 1992, selon l'Enquête suisse de santé de l'Office fédéral de la statistique, 16,3 % des jeunes Suisses âgés de 15 à 35 ans ont indique avoir déjà consommé du haschisch au moins une fois dans leur vie. En 1997, ils étaient 26,7 % à donner la même réponse. Tous les pays de l'OCDE constatent la même tendance. Ainsi, aux États-Unis par exemple, la prévalence à vie de la consommation de cannabis chez les personnes âgées de 18 ans est passée de 32,6 % en 1992 à 49,6 % en 1997. »*[158]

Le projet de révision sur le cannabis repose aussi sur le constat, **que nous partageons entièrement**, que «la littérature scientifique disponible ne permet pas d'établir un rapport entre la sévérité de la législation et la prévalence à vie de la consommation de cannabis ».[159] Il souligne aussi que :

> *« Les faiblesses de la loi actuelle apparaissent au grand jour dès qu'il s'agit de lutter contre la culture du chanvre servant à la production de stupéfiants et contre la production et la vente de produits à base de cannabis. Dans ce domaine, l'application de la loi est très hétérogène et fort onéreuse; il en résulte un marché gros très difficile à contrôler, qui s'est ramifié au-delà de nos frontières. D'ailleurs, la nécessité de réviser les dispositions applicables en la matière n'est pour ainsi dire pas contestée. »*[160]

La révision de la loi vise donc notamment à :

---

157 Voir le témoignage de Mme Diane Steber Büchli, Office fédéral de la Santé publique de Suisse devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 4 février 2002, fascicule 13.

158 Conseil fédéral suisse (2001) *Message concernant la révision de la loi sur les stupéfiants*, page 3554-3555.

159 *Ibid.*, page 3560.

160 *Ibid.*, page 3540.

- Adapter la loi à a réalité ;
- Dépénaliser la consommation de cannabis et ses actes préparatoires ;
- Renforcer la protection de la jeunesse ;
- Réglementer la culture, la fabrication et le commerce du cannabis ;
- Restreindre l'obligation de poursuivre ;
- Renforcer la répression dans certains domaines de manière ciblée.[161]

Plus précisément, le projet prévoit (art. 19c) la dépénalisation de la consommation de stupéfiants à effet de type cannabique ainsi que les actes préparatoires à la consommation personnelle commis sans donner à un tiers la possibilité d'en consommer. Bien que le projet ne précise pas les limites spécifiques aux quantités – il reviendrait aux tribunaux de déterminer si les quantités justifient la consommation personnelle – la documentation gouvernementale suggère néanmoins qu'aux fins de possession et de culture pour usage personnel, les quantités retenues seraient de 30 grammes et de dix plantes de taille moyenne respectivement. Le document précise aussi que les quantités varieraient selon la personne mise en cause, l'usage, etc. [162]

L'article 19d attribue au Conseil fédéral le pouvoir – et non l'obligation – de fixer des priorités dans la poursuite pénale. Selon ce principe le Conseil fédéral, en consultation avec les cantons, fixerait les conditions de limitation des poursuites pénales, pour autant qu'elles s'inscrivent à l'intérieur des balises décrites au paragraphe suivant.[163]

Si le Conseil fédéral use de son pouvoir en vertu de l'article 19d, l'article 19f définit les conditions sous lesquelles la culture, la fabrication et le commerce de chanvre et de ses dérivés serait permise. La distribution ne fera pas l'objet de poursuite s'il n'y a pas vente aux personnes de moins de 18 ans, le produit ne présente pas un risque sérieux pour la santé, l'ordre public est maintenu, il ne se fait aucune publicité, etc. et se conforme à des critères rigoureux de résidence et d'âge. Les producteurs doivent se soumettre aussi à un ensemble de règles strictes : ne produire que pour des points de vente sis en Suisse et être en mesure d'en faire la preuve ; notifier les autorités sur toutes les cultures, (avec indication des espèces, de la superficie, du lieu, des destinataires, etc.) ; et spécifier la teneur en THC. Le Conseil fédéral peut établir des règles sur la dimension et la conformation des zones de culture, le nombre de centres de distribution, etc. Les cantons seraient aussi autorisés à adopter des règles plus strictes, notamment sur les zones cultivées et les centres de distribution.[164]

Le Conseil a demandé des avis juridiques sur la compatibilité de ces propositions avec les trois conventions internationales.[165] Les deux avis s'entendent sur la

---

[161] *Ibid.*, page 3556.
[162] *Ibid.*, pages 3596-3597.
[163] *Ibid.*, page3598.
[164] *Ibid.*, page 3600.
[165] Nous avons déjà présenté, au chapitre 19, les conclusions d'un des experts consultés.

conformité de la décriminalisation de l'usage personnel et des actes afférents en vertu des conventions. De plus, la limitation des poursuites pénales pour la culture, la production et la distribution serait aussi en conformité. Le *Message* du Conseil fédéral conclut que :

> *« Les deux avis de droit en arrivent pour l'essentiel aux mêmes conclusions. La seule différence réside dans la question de savoir si, dans le cas où la limitation de poursuite pénale dans les domaines de la culture du cannabis et de la fabrication et du commerce de produits du cannabis serait introduite, les dispositions sont suffisantes ou si elles devraient être complétées par un système de licence. À ce propose, il y a lieu de remarquer que les Pays-Bas connaissent également une limitation partielle de l'obligation de poursuivre dans les domaines cités et qu'ils n'ont pas introduit un système de licence. Or le système hollandais n'a encore jamais été contesté dans son principe comme étant incompatible avec les conventions de l'ONU. »* [166]

Administration de la politique suisse en matière de drogue

La Confédération est la plaque tournante de la politique en matière de drogue en Suisse, de la coordination et de l'harmonisation des différentes politiques et mesures mises en œuvre par les cantons, les villes, les communes et les institutions privées. Selon l'article 15c de la LStup, les tâches suivantes incombent à la Confédération :

> [1] La Confédération encourage, par l'octroi de subventions ou par d'autres mesures, la recherche scientifique sur les effets des stupéfiants, les causes et les conséquences de leur abus et les moyens de le combattre.
>
> [2] Le Conseil fédéral définit les modalités relatives à l'octroi et au calcul des subventions et en fixe le montant.
>
> [3] La Confédération prête ses services aux cantons et aux organisations privées pour l'exécution de la loi. Elle crée, notamment, un office de documentation, d'information et de coordination et encourage la formation du personnel spécialisé dans le traitement de personnes dépendantes. Le Conseil fédéral en règle les modalités.

Selon l'article 15a, les tâches suivantes incombent aux cantons :

[166] Conseil fédéral, *ibid.*, page 3621.

> [1] Pour prévenir l'abus des stupéfiants, les cantons encouragent l'information et les consultations et créent les institutions nécessaires à cet effet.
>
> [2] Les cantons pourvoient à la protection des personnes dont l'état requiert un traitement médical ou des mesures d'assistance en raison d'un abus de stupéfiants et favorisent la réintégration professionnelle et sociale de ces personnes.
>
> [3] Les autorités compétentes peuvent déléguer certaines tâches et attributions à des organisations privées.
>
> [4] Les cantons peuvent interdire l'acquisition de stupéfiants. Ils notifient leurs décisions à l'Office fédéral de la santé publique. Celui-ci en informe les autorités sanitaires des autres cantons, à l'intention des médecins et des pharmaciens.
>
> [5] Les cantons soumettent à une autorisation spéciale la prescription, la dispensation et l'administration des stupéfiants destinés au traitement des personnes dépendantes.
>
> [6] Lorsque, du fait de sa dépendance, une personne pourrait constituer un danger pour la circulation publique, le service qui en a connaissance avise l'office compétent en la matière.

L'application de la LStup relève, en principe, de la compétence des cantons, puisque la procédure pénale est de leur ressort. Une procédure pénale au niveau cantonal se déroule généralement en plusieurs étapes : enquête de la police, instruction judiciaire, décision de non-lieu ou de renvoi devant le tribunal et décision du tribunal. Dans les cas de peu de gravité, punissables d'une amende ou des arrêts, comme c'est le cas de plusieurs infractions à la LStup, une décision pénale peut être prononcée par une autorité administrative (p. ex., le préfet). L'intéressé a cependant le droit de s'opposer à un tel type d'autorité et d'être jugé par un tribunal, généralement un tribunal de police constitué par le Président (juriste), qui siège seul. Les cas de gravité moyenne sont généralement jugés par un tribunal de district (tribunal correctionnel), présidé par un juge professionnel juriste, assisté par des juges laïcs. Enfin, les délits les plus graves sont entendus par des cours d'assises composées au moins d'un président juriste et d'un jury de citoyens. Toutefois, puisque ce genre de procédure est long, compliquéet coûteux, la plupart des cantons tendent à remplacer les cours d'assises soit par les

tribunaux de district, soit par un tribunal supérieur formé de juges permanents (tribunal criminel).[167]

Par ailleurs, la Confédération joue également un rôle dans la lutte contre le trafic de drogue puisqu'en vertu de l'article 29 de la LStup, l'Office fédéral de la police (OFP) est l'office central suisse chargé de réprimer le trafic illicite des stupéfiants. L'OFP recueille les renseignements propres à prévenir les infractions à la LStup et à faciliter la poursuite des délinquants. Pour l'exécution de ces tâches, l'Office est en rapport avec d'autres offices intéressés de l'administration fédérale (Office de la santé publique, Direction générale des douanes, la direction générale de la Poste Suisse, les autorités cantonales de police, les offices centraux des autres pays et l'Organisation internationale de police criminelle (Interpol). L'OFP constitue pour ses partenaires cantonaux et internationaux un pôle d'information, de coordination et d'analyse dans le domaine de la sûreté intérieure suisse.[168] Depuis 1996, après une phase d'essai, l'Office exploite une banque de données en matière de drogue – DOSIS. Cette banque de données est un outil précieux pour les cantons. Les brigades cantonales des stupéfiants sont raccordées au système et peuvent accéder directement à DOSIS puisqu'ils leur incombent, de même qu'à l'OFP, d'y enregistrer des informations. Ce système favorise ainsi la collaboration entre l'OFP et les autorités cantonales de police. Les informations enregistrées dans le système ne concernent que le commerce illicite de stupéfiants; les données relatives à de simples consommateurs de drogue en sont exclues.[169]

Statistiques sur l'usage de stupéfiants et les infractions à la LStup

Cette section reprend divers passages d'une publication de l'OFP intitulée *Situation Suisse : Rapport de situation 2000*[170], préparée par le Service d'analyse et de prévention à titre de produit de transition, puisqu'un rapport exhaustif sera publié en 2002. Par ailleurs, il faut noter que les statistiques rapportées dans ce rapport présentent des lacunes méthodologiques. D'une part, la Suisse est un État fédéral qui compte 26 entités cantonales (cantons et demi-cantons), et les infractions ne sont pas enregistrées et comptabilisées selon les mêmes critères dans tous les cantons. D'autre part, la statistique ne permet pas de contrôler le phénomène de double comptage ou de comptage multiple, car certains suspects peuvent se manifester à plusieurs reprises

---

167 Tribunal fédéral, *L'organisation judiciaire en Suisse*, disponible en ligne à l'adresse : http://www.bger.ch/index.cfm?language=french&area=Federal&theme=system&page=content&maskid=195

168 Office fédéral de la police, *Un aperçu de l'OFP*, disponible en ligne à l'adresse http://www.bap.admin.ch/f/index.htm.

169 Office fédéral de la police, *Exploitation définitive de la banque de données en matière de drogue DOSIS*, 26 juin 1996, disponible en ligne à l'adresse http://www.bap.admin.ch/f/index.htm.

170 Office fédéral de la police, *Situation Suisse : Rapport de situation 2000*, Service d'analyse et de prévention, 2001, disponible en ligne à l'adresse http://www.bap.admin.ch/f/index.htm.

durant la même année ou dans divers cantons. Enfin, seule une partie des actes criminels visés par le code pénal sont pris en compte.[171]

Usage

Voici les tendances observées dans ce rapport en 2000 :

- Forte augmentation de la consommation de marijuana ;
- Forte augmentation de la consommation de cocaïne ;
- Forte augmentation de la polytoxicomanie (consommation de plusieurs sortes de stupéfiants) ;
- Forte augmentation de la consommation de drogues de synthèse (amphétamines et méthamphétamines) – les pilules thaïes[172] sont devenues la drogue à la mode ;
- Tendance à la baisse de la consommation d'héroïne par injection ;
- Quasi-inexistence de scènes ouvertes de la drogue dans les villes suisses ;
- 205 décès dus à la drogue et enregistrés par la police (on en comptait 405 en 1991) – les plus de 27 ans constituent le groupe d'âge le plus touché chez les hommes comme les femmes ; Zurich et Berne sont les cantons les plus touchés avec respectivement 50 et 36 décès dus à la drogue ; et
- Les 18 à 24 ans demeurent le groupe d'âge le plus fréquent en ce qui concerne la consommation de marijuana, de haschich et d'hallucinogènes et les plus de 30 ans, en ce qui concerne la cocaïne et l'héroïne.[173]

Infractions

Pour ce qui est des infractions à la LStup, le nombre de dénonciations s'élevait à 46 558 en 2000, une hausse par rapport à 44 307 en 1999. Il s'agit d'une hausse importante par rapport à 1990, année où on comptait 18 800 dénonciations. Une comparaison des dénonciations selon le type de délit entre 1997 et 2000 démontre que les dénonciations pour trafic, contrebande et délits mixtes présentent une tendance à la

---

[171] *Ibid.*, page 7.

[172] Selon un communiqué de l'Office fédéral de la police, les pilules thaïes renferment de la métamphétamine et leur structure est proche de celle de l'ecstasy. Elles proviennent de Thaïlande, où elles sont connues sous le nom de « Yaba » (drogue qui rend fou). Les tablettes sont marquées des deux lettres « WY » et sentent la vanille. La substance est généralement fumée, à l'aide d'une feuille d'aluminium, ou absorbée. Le risque de dépendance chez les personnes absorbant le produit en le fumant est au moins trois fois plus élevé que chez les consommateurs d'ecstasy. Cette drogue est un puissant excitant dont les effets peuvent être comparés à ceux du crack, à l'exception près qu'ils durent plus longtemps. La consommation de ces pilules peut provoquer des dommages physiques et psychiques irréparables (pertes de mémoire, dépressions). Elle peut également causer des hallucinations paranoïaques et des accès de violence et entraine une dépendance psychique plus rapidement que l'ecstasy.

[173] OFSP (2000) *op. cit.*, pages 17-37.

baisse, alors que les dénonciations pour consommation de stupéfiants ont augmenté, sauf en 1999.[174]

En 2000, les dénonciations enregistrées pour trafic étaient au nombre de 3 021, un recul de 18,5 % par rapport à l'année précédente où l'on comptait 3 711 dénonciations. Certains cantons affichent cependant une hausse importante des dénonciations, en particulier Bâle-Ville qui présente une augmentation de 31 %. Le rapport invite à la prudence dans l'interprétation de ces données, suggérant que le recul des dénonciations n'est probablement pas dû à une amélioration de la situation dans les cantons concernés, mais à une baisse du nombre de dénonciations effectuées par la police, baisse liée à l'étendue croissante des procédures d'enquête et à la mobilisation des effectifs policiers dans d'autres domaines. Il est important de souligner que sur un total de 3021 dénonciations pour trafic de stupéfiants, 78 % des auteurs des délits étaient étrangers et 22 %, suisses. En ce qui a trait au sexe des personnes dénoncées, 82 % étaient des hommes et 7 %, des femmes (sexe inconnu des 11 % restants). Chez les hommes, les 18 à 24 ans représentaient, avec 45 %, le groupe d'âge le plus représenté. Chez les femmes, c'est le groupe d'âge des plus de 30 ans qui vient en tête avec 56 %, suivi des 18 à 24 ans avec 27 %.[175]

---

174 *Ibid.*, pages 18-19.
175 *Ibid.*, pages 20-23.

L'AUSTRALIE[176]

De façon générale, le cannabis était peu connu ou utilisé en Australie avant les années 1960. Néanmoins, les lois sur les drogues qui furent adoptées dans la majorité des États et des Territoires vers la fin des années 1800 et le début des années 1900 (principalement en raison du grand nombre de Chinois qui fumaient de l'opium) constituaient un cadre se prêtant bien à l'interdiction du cannabis. Les premières mesures australiennes visant à contrôler l'usage du cannabis font partie d'une loi adoptée en 1928 dans l'État de Victoria pour sanctionner l'usage non autorisé du chanvre indien et de la résine de chanvre indien. On adopta par la suite des lois semblables dans les autres États du Commonwealth. Les peines liées à la culture, à la possession et à l'usage de cannabis étaient en général plutôt sévères dans les années 1960 et 1970.[177]

L'incitation à réviser les lois sur l'usage du cannabis en Australie-Méridionale découle des recommandations faites en 1979 dans le rapport de la *South Australian Royal Commission into the Non-Medical Use of Drugs.*[178] On y recommande entre autres choses de ne pas assimiler la consommation à petite échelle de cannabis à une infraction criminelle. À l'appui de cette recommandation, la Commission royale mentionne plusieurs États d'outre-mer, y compris dix États américains, où une telle mesure a donné de bons résultats.

Stratégie nationale sur les drogues[179]

Campagne nationale contre la toxicomanie (1985-1992)

Lancée en 1985, la Campagne nationale contre la toxicomanie (CNCT), cœur de la politique australienne en matière de drogues, a permis de centrer l'attention sur la santé publique et sur la minimisation des méfaits de la toxicomanie. En effet, la CNCT faisait valoir que la toxicomanie devait être assimilée avant tout à une question de santé. La décision de faire relever le programme de la compétence du ministère fédéral de la Santé plutôt que du ministère fédéral du Procureur général fut prise délibérément, en

---

176 Cette section s'inspire notamment du texte préparé pour le Comité spécial par la Bibliothèque du Parlement : MacKay, R., (2001) *Politique nationale sur les drogues : l'Australie.* Ottawa : Bibliothèque du Parlement, rapport préparé pour le Comité spécial du Sénat sur les drogues illicites. Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp

177 Afin d'avoir un historique des lois australiennes concernant le cannabis, voir : McDonald *et al.*, *Legislative Options for Cannabis Use in Australia*, Commonwealth d'Australie, 1994, disponible en ligne à :http://www.druglibrary.org/schaffer/Library/studies/aus/cannabis.htm.

178 South Australian Government, Royal Commission of Inquiry into the Non-Medical Use of Drugs South Australia 1979, *Rapport final* (président : Sackville).

179 Afin de connaitre les grandes lignes de la Stratégie nationale sur les drogues de 1985 à nos jours, voir : http://www.aic.gov.au/research/drugs/strategy/index.html.

raison, du moins en partie, de l'apparition du VIH/SIDA. Mais il convient de souligner que le programme a été marqué, dès sa mise en place, par une étroite collaboration entre le Commonwealth (c'est-à-dire le gouvernement fédéral), les États et les Territoires. Ce programme visait l'instauration d'un partenariat des secteurs de la santé et des services de police dans le cadre d'une stratégie globale fondée sur une démarche intégrée de gestion de la consommation des drogues licites et illicites.

La notion de réduction des méfaits de la toxicomanie intègre les stratégies de contrôle de l'approvisionnement en drogues, de contrôle de la demande de drogues et de réduction des méfaits. Ce que vise l'Australie dans le contexte de sa stratégie sur les drogues, c'est d'améliorer l'état de santé, la condition sociale et les conditions économiques de ses citoyens en prévenant l'usage de drogues nocives et en réduisant les effets nocifs sur la santé des drogues licites et illicites.

Stratégie nationale sur les drogues (1993-1997)

Afin d'appliquer la nouvelle stratégie sur les drogues, on avait besoin de données fiables, de nouvelles modalités d'intervention et d'une évaluation de la démarche. C'est dans ce contexte que le *Ministerial Council on Drug Strategy* (MCDS) a commandé deux évaluations distinctes de la CNCT, afin de faire le point sur la situation et de faire les recommandations pertinentes. À la lumière des résultats de ces deux évaluations, publiées la première en 1988 et l'autre en 1992, la campagne a été relancée sous le nom de Stratégie nationale sur les drogues (SND). Incorporant les recommandations faites à la suite des deux évaluations, la Stratégie a continué d'accorder une importance particulière aux principes de réduction des risques de la toxicomanie. Ses objectifs sont de :

- Réduire au minimum l'incidence de maladies, d'affections, de blessures et de décès prématurés liés à l'usage de l'alcool, du tabac, des médicaments et des drogues illicites ;
- Réduire au minimum l'incidence et l'impact des infractions criminelles et des autres actes criminels, violents et antisociaux liés à la drogue au sein de la collectivité ;
- Réduire au minimum les perturbations de nature personnelle et sociale, la perte de la qualité de vie, la baisse de productivité et les autres coûts économiques liés à l'usage excessif de l'alcool et des autres drogues ;
- Empêcher la propagation de l'hépatite, du VIH/SIDA et des autres maladies infectieuses liées à l'usage de drogues injectables dans des conditions insalubres.

Le plan stratégique reposait sur six éléments précis de soutien de l'élaboration et de la mise en œuvre de la politique en matière de drogues, soit la minimisation des méfaits de la toxicomanie, la justice sociale, le maintien des moyens de contrôle de l'approvisionnement en drogues, une approche intersectorielle, la coopération internationale, ainsi que le tandem évaluation et responsabilité.

La responsabilité pour les orientations générales et l'application de la SND incombe au MCDS, lequel se compose des ministres responsables des secteurs de la santé et des services de police de chacun des états et territoires, et du gouvernement fédéral ou Commonwealth. Le Conseil se réunit une fois l'an. Le soutien administratif dont bénéficie le MCDS est assuré par le *National Drug Strategy Committee* (NDSC). Celui-ci a le mandat de préparer des projets liés à la SND, d'en assurer la mise en œuvre, d'élaborer des énoncés de politique concernant les drogues licites et illicites, et d'assurer la liaison avec les autres organismes gouvernementaux pour toutes les questions touchant la SND. Le Comité est composé d'un représentant du secteur de la santé et d'un représentant des services de police de chacun des états et territoires, et du gouvernement fédéral. Le MCDS et le NDSC élaborent des politiques et des orientations nationales de concert avec le gouvernement central et les états et territoires individuels, puis se chargent de mettre en œuvre, au besoin, ces politiques et orientations dans leurs milieux sociaux, politiques et économiques.

Évaluation de la Stratégie nationale sur les drogues (1997)[180]

En 1997, on a publié un rapport d'évaluation de la Stratégie nationale sur les drogues (1993-1997). Ce rapport, intitulé *The National Drug Strategy: Mapping the Future*, observe que la SND a su allier de façon unique les éléments suivants, qui, selon ses auteurs en ont fait un modèle sur la scène internationale :

- Elle reconnaît la complexité des enjeux liés aux drogues et la nécessité d'offrir aux professionnels de la santé de première ligne et aux autres intervenants en toxicomanie un vaste éventail d'options fondées sur la notion de minimisation des méfaits ;
- Elle s'attaque à l'ensemble du problème, c'est-à-dire à l'abus de drogues licites et illicites ;
- La démarche de la SND en matière de drogues est fondée avant tout sur la concertation entre le secteur de la santé, les services de police, le secteur de l'éducation, les organismes non gouvernementaux et l'industrie privée ; et
- Elle adopte une approche équilibrée, c'est-à-dire en maintenant un équilibre approprié entre la participation du Commonwealth, des États et des Territoires, un équilibre entre les stratégies de réduction de l'offre et de la demande de drogues, ainsi qu'un équilibre entre le traitement, la prévention, la recherche et l'éducation.

Contrairement à ce que plusieurs craignaient, à savoir que les politiques de réduction des risques mèneraient à une acceptation et un usage accrus de drogues illicites, l'évaluation a permis de constater qu'il n'y avait pas eu augmentation de la

[180] Voir Single, E. et T. Rohl, (1997) *The National Drug Strategy: Mapping the Future*, Rapport commandé par le Ministerial Council on Drug Strategy, Canberra. Disponible en ligne à : http://www.health.gov.au/pubhlth/publicat/document/mapping.pdf.

consommation de drogues comme l'héroïne, les amphétamines et la cocaïne, mais que la consommation de marijuana avait légèrement augmenté. On a également constaté que la SND avait contribué à enrayer la propagation du VIH, de l'hépatite C et d'autres maladies infectieuses chez les utilisateurs de drogues injectables.

Cadre stratégique national en matière de drogues (1998/1999-2002/2003)[181]

Le Cadre stratégique national en matière de drogues repose sur les principes directeurs de la Stratégie nationale et sur les recommandations du rapport d'évaluation de la phase antérieure. Il confirme les principes de la réduction des méfaits et de l'équilibre entre les stratégies de réduction de l'offre et de la demande, tout en mettant l'accent sur une meilleure intégration entre les diverses stratégies. Il continue également de mettre l'accent sur la pratique fondée sur la connaissance, qui doit être appuyée par la recherche et une évaluation rigoureuse, incluant la détermination de la rentabilité des interventions.

Au cours de cette phase subséquente de la SND, l'accent est mis sur l'extension du partenariat existant entre les organismes de santé et de police à plusieurs autres partenaires, tel que le recommandait le rapport d'évaluation. Ainsi s'ajouteront des représentants des portefeuilles des douanes et de l'éducation à *l'Intergovernmental Committee on Drugs*, qui est composé d'agents de santé et d'agents de la force publique de chacun des états et territoires d'Australie, ainsi que du gouvernement fédéral. Le MCDS bénéficie aussi du soutien de *l'Australian National Council on Drugs*, composé de personnes des secteurs gouvernementaux, non gouvernementaux et des collectivités possédant les compétences nécessaires pour donner des conseils appropriés en matière de politique. Ces organismes doivent élaborer une série de Plans d'action nationaux sur les drogues, précisant les priorités en matière de réduction des méfaits liés à l'usage des drogues licites et illicites, les stratégies d'intervention selon ces priorités et les indicateurs de rendement.

Stratégie nationale sur les drogues illicites (1998 –)[182]

En 1997, la Stratégie nationale sur les drogues illicites, « *Tough on Drugs* » a été annoncée et sa mise en œuvre amorcée en 1998. Cette stratégie comprend un éventail de mesures de réduction de l'offre et de la demande de drogues et prévoit un budget total de 516 millions $A. Les fonds affectés à la Stratégie sont répartis entre les stratégies de réduction de la demande en drogues, dont la mise en œuvre incombe au *Department of Health and Aged Care* et au *Department of Education, Training and Youth Affairs*,

---

181 Ministerial Council on Drug Strategy, *National Drug Strategic Framework 1998-99 to 2002-03: Building Partnerships*, document rédigé pour le compte du Ministerial Council par un comité directeur mixte de l'Intergovernmental Committee on Drugs et l'Australian National Council on Drugs, Canberra, novembre 1998. Disponible en ligne à http://www.health.gov.au/pubhlth/nds/resources/publist.htm.

182 Pour avoir de plus amples détails sur la Stratégie nationale sur les drogues illicites, consulter le site Web de l'Australian Department of Health and Aged Care : http://www.health.gov.au/pubhlth/strateg/drugs/illicit.

et les stratégies de réduction de l'approvisionnement de drogues, qui relèvent de *l'Attorney-General's Department*, de *l'Australian Federal Police* et de *l'Australian Customs Service*. Une somme de 213 millions $ est consacrée aux mesures de réduction de l'offre axées sur l'interception de plus grandes quantités de drogues aux frontières australiennes et en Australie même. En matière de maintien de l'ordre, on a accordé les fonds à la mise sur pied et au fonctionnement de 10 nouvelles équipes mobiles d'intervention antidrogues de la Police fédérale pour lutter à anéantir les groupes criminels australiens de la drogue, et on a augmenté les fonds alloués à *l'Australian Customs Service* pour lui permettre d'accroître sa capacité d'interception des envois de drogues.

Un montant de 303 millions $ est consacré aux mesures de réduction de la demande de drogues, portant sur cinq axes prioritaires d'intervention :

- Traitement des usagers de drogues illicites, y compris la détermination des meilleures pratiques en la matière.
- Prévention de l'usage de drogues illicites.
- Formation et acquisition des compétences à l'intention des intervenants de première ligne qui sont en contact direct avec les usagers de drogues.
- Surveillance et évaluation, y compris la collecte de données.
- Recherche.

Corrélativement avec la nouvelle stratégie, on a créé *l'Intergovernmental Committee on Drugs*, dont le rôle est de fournir des conseils d'orientation stratégique aux ministres du gouvernement sur une gamme complète de questions liées aux drogues.

En juin 1999, les ministres de la santé et les ministres responsables des services de police du Commonwealth, des États et des Territoires se sont entendus sur une démarche nationale d'élaboration d'une initiative de déjudiciarisation dont l'objectif est de soustraire les usagers de drogues illicites de la procédure pénale traditionnelle au profit d'une démarche d'éducation et de traitement. L'initiative se traduit par un ensemble d'interventions progressives adaptées à la gravité de l'infraction et à la situation du contrevenant, mais ne s'applique pas aux délits liés au trafic de drogue. La personne accusée de posséder une petite quantité de drogue peut faire l'objet d'un avertissement ; on peut alors lui fournir les renseignements qui lui permettront de se faire traiter, la référer pour évaluation ou pour suivre un traitement, sans l'incarcérer, pourvu que le délit ne soit pas grave et ne constitue pas une menace pour la société. Les tribunaux et les systèmes correctionnels peuvent également exiger que le contrevenant participe à un traitement dans la collectivité comme condition à sa probation ou à sa libération conditionnelle. La possibilité de traitement existe également dans les organismes correctionnels et les communautés thérapeutiques et maisons de transition exploitées ou financées par les services correctionnels.[183]

---

[183] Pour plus amples informations, voir : Ministerial Council on Drug Strategy, *National Action Plan on Illicit Drugs, 2001 to 2002-03*, document rédigé par le National Expert Advisory Committee on Illegal

Évaluation de la Stratégie nationale sur les drogues (2001)[184]

Fondée sur la notion de réduction des risques plutôt que sur l'éradication de l'usage de drogue, la SND reconnaît la complexité des enjeux liés aux drogues et la nécessité d'offrir aux professionnels de la santé de première ligne et aux autres intervenants en toxicomanie un vaste éventail d'options pertinentes. Celles-ci vont des interventions axées sur l'abstinence aux programmes axés sur la réduction des conséquences de l'usage de drogues chez les toxicomanes dont le sevrage ne peut être envisagé dans un avenir immédiat. L'établissement des buts, des stratégies, des principes directeurs et des indicateurs de rendement de la SND incombe à un *National Drug Strategy Committee.* Ce comité se compose de hauts fonctionnaires des ministères de la santé et des ministères responsables des services de police de chacun des états et territoires, ainsi que de leurs homologues fédéraux. Cette collégialité en matière de prise de décisions est l'élément clé de la SND, car elle met l'accent sur la collaboration entre les différents paliers de gouvernement et assure un haut niveau de visibilité à la stratégie en matière de drogues.

Le professeur Single a souligné que le gouvernement australien avait donné suite à bon nombre de recommandations qui lui avaient étaient faites pour améliorer la SND. On a, par exemple, reconduit la SND pour une période de cinq ans, on en a augmenté le financement, on a créé une unité SND spécialisée au sein du ministère de la Santé fédéral et on a élaboré des plans d'action relativement à d'autres recommandations.[185]

Le cadre législatif

Sous le régime fédéral australien, le droit pénal et l'exécution des lois en matière de drogues relèvent principalement des gouvernements des États du Commonwealth. Par ailleurs, l'Australie ayant ratifié les trois principales conventions internationales sur les drogues illicites, les obligations qui en découlent sont exécutées en vertu de trois lois fédérales : la *Narcotic Drugs Act* de *1967*, la *Psychotropic Substances Act* de *1976* et la *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act* de *1990.*

Lois sur les drogues dans les États du Commonwealth d'Australie

En Australie, c'est aux États et aux Territoires qu'incombent la promulgation et l'application des lois sur les drogues illicites. Le droit à ce sujet varie sensiblement selon

---

Drugs, Canberra, juillet 2001. Disponible en ligne à : http://www.health.gov.au/pubhlth/nds/resources/publist.htm.

[184] Voir le témoignage du professeur Eric Single devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, mai 2001. Disponible en ligne à l'adresse www.parl.gc.ca/drogues-illicites.asp

[185] *ibid.*

les états et les territoires, mais sa structure, de façon générale, varie peu. Les principales lois en la matière sont les suivantes dans les différents états et territoires :

Nouvelle-Galles du Sud	*Drug Misuse and Trafficking Act 1985*; *Drug Court Act 1998*
Victoria	*Drugs, Poisons and Controlled Substances Act 1981*
Queensland	*Drugs Misuse Act 1986*; *Drug Rehabilitation (Court Diversion) Act 2000*
Australie-Occidentale	*Misuse of Drugs Act 1981*
Australie-Méridionale	*Controlled Substances Act 1984*
Tasmanie	*Poisons Act 1971*
Territoire du Nord	*Drugs of Dependence Act 1990*
Territoire de la capitale de l'Australie	*Drugs of Dependence Act 1989*
Commonwealth	*Customs Act 1901* *Narcotic Drugs Act 1967* *Psychotropic Substances Act 1976* *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990*[186]

Chaque loi crée, sous une forme ou une autre, les infractions de possession, d'usage, de culture, de production et de trafic, de fourniture et de distribution. Les lois renferment également de longues annexes où figurent les drogues interdites et les différentes quantités afférentes, comme les quantités « traficables » et les quantités « commerciales ». Ces quantités servent à établir les peines maximales qui peuvent être infligées.

Les peines maximales pour les infractions graves, comme le trafic de drogues en « quantités commerciales », varient de 25 ans d'emprisonnement à l'emprisonnement à perpétuité; il convient de préciser que tous les états et territoires, à l'exception du Queensland, ont établi des peines maximales inférieures pour les infractions liées au cannabis. En vertu de la plupart de ces lois, une peine d'emprisonnement peut être infligée à toute personne déclarée coupable d'une infraction de possession simple ou d'usage, mais il est très rare qu'une telle peine soit imposée. En ce qui concerne tout particulièrement les infractions de moindre gravité, il existe souvent un écart substantiel entre les peines prévues par la loi et les peines infligées. À titre d'exemple, au

[186] On peut avoir accès aux lois sur les drogues illicites en vigueur dans les états et territoires à : http://www.aic.gov.au/research/drugs/context/legislation.html.

Queensland, où toute personne déclarée coupable de possession est passible d'une peine de 15 ans d'emprisonnement et d'une amende maximale de 300 000 $A, la peine usuelle infligée par le tribunal correctionnel, où la très grande majorité des affaires de possession sont instruites, est une amende de quelques centaines de dollars, souvent sans relevé de la condamnation.[187]

Depuis 1987 en Australie-Méridionale, 1992 dans le Territoire de la capitale de l'Australie et 1996 dans le Territoire du Nord, les personnes prises à commettre une infraction « mineure » liée au cannabis n'ont pas à comparaître devant le tribunal si elles acquittent « sur-le-champ » une amende relativement faible. Bien que la possession de cannabis soit toujours interdite, on inflige au contrevenant une sanction civile plutôt que criminelle. De plus, dans l'État de Victoria, la loi prévoit l'imposition de garanties précédant l'imposition de la peine pour les délinquants primaires accusés d'une infraction mineure liée aux drogues (*Drugs Poisons and Controlled Substances Act 1981*, s. 76). On impose des garanties aux délinquants primaires et la condamnation, le cas échéant, n'est pas portée au dossier de la personne si celle-ci respecte les garanties imposées. Mais dans l'État de Victoria, en Nouvelle-Galles du Sud, en Tasmanie, au Queensland et en Australie-Occidentale, toute forme de possession, d'usage et de fourniture de cannabis est criminellement interdite et entraîne des sanctions criminelles. De plus, dans tous les états et territoires, les peines imposées pour les infractions liées à des quantités commerciales sont toujours sévères, plus particulièrement si l'infraction se situe à l'extrémité supérieure de l'échelle.

Dans les états et territoires où l'interdiction liée au cannabis est à caractère civil, les infractions qui entraînent un avis d'infraction au civil comprennent la possession de petites quantités de cannabis (jusqu'à 100 g en Australie-Méridionale, 25 g dans le Territoire de la capitale de l'Australie et 50 g dans le Territoire du Nord) et la culture de plantes de cannabis (jusqu'à trois en Australie-Méridionale, cinq dans le Territoire de la capitale de l'Australie et deux dans le Territoire du Nord). Le contrevenant qui n'acquitte pas l'amende qui lui est imposée s'expose à une comparution devant le tribunal et à une condamnation.

Les états et territoires où l'interdiction liée au cannabis est à caractère criminel, viennent d'adopter des dispositions de mise en garde visant la « déjudiciarisation », en vertu desquelles les délinquants primaires ou secondaires qui commettent un délit de possession ou d'usage de cannabis peuvent faire l'objet uniquement d'une mise en garde ou sont tenus de se présenter à des séances d'information et d'orientation, plutôt que de comparaître devant le tribunal.

Quatre états ont établi des « tribunaux spéciaux sur les drogues » soit le Queensland, la Nouvelle-Galles du Sud, l'Australie-méridionale et l'État de Victoria. Au Queensland et en Nouvelle-Galles du Sud, ces tribunaux de « déjudiciarisation » ont

---

[187] Pour en savoir plus sur les lois australiennes en matière de drogues, voir : Brereton, D., « The History and Politics of Prohibition », in *Drugs and Democracy*, *op. cit.*

été établis en vertu de dispositions législati
dans l'État de Victoria, ils existent et fonctio

L'une des particularités des lois aus
renversement du fardeau de la preuve. Ain
renferme une «disposition déterminative » p
découverte de drogues interdites dans des lo
possession de la drogue par la personne oc
parvienne à convaincre le tribunal qu'elle «
croire qu'il y avait de la drogue dan
(paragraphe 57(c)). De même, en vertu de
Commonwealth, toute personne trouvée e
drogue doit prouver, en se fondant sur la pré
nullement l'intention de faire un trafic comm
personne sera condamnée sur la présomption

Les lois australiennes en matière de dr
pouvoirs aux services de police et aux autr
déceler les infractions en matière de drogues
Drugs Misuse Act 1986 du Queensland, par ex
lorsqu'ils font enquête sur la possession d'
quantité, à faire des barrages routiers et à
automobiles, à détenir et fouiller des personn
pénétrer dans des locaux et les fouiller avec
s'agit de délits comme le trafic de drogue
peuvent demander au tribunal de leur perm
les locaux privés.

En vertu de la *Telecommunications (Inte*
organismes d'application de la loi à l'échelon
à l'exception du Queensland sont autoris
lorsqu'ils mènent des enquêtes concernant d

Au cours de la dernière décennie, les
adopté également des lois leur permettant
afin de pouvoir s'attaquer aux narcotrafiq
souvent, cette action ne peut être prise, qu'
Nouvelle-Galles du Sud, l'ordonnance de co
condamnation, si la Cour suprême est c
probabilité » s'est livrée à des activités li
Act 1990).

[108] Pour en savoir plus sur les tribunaux con
http://www.aic.gov.au/research/drugs/context/co

es, tandis qu'en Australie-Méridionale et
ient de façon plus ou moins officielle.[188]
aliennes en matière de drogues est le
, la *Drugs Misuse Act 1986* (Queensland)
ur le délit de possession, de sorte que la
ux constitue une preuve *prima faciae* de la
ipant les locaux, à moins que celle-ci ne
ie savait pas ou que rien ne la portait à
les locaux où elle a été trouvée »
l'article 235 de la *Customs Act 1901* du
possession d'une certaine quantité de
ondérance des probabilités, qu'elle n'avait
ercial de cette drogue, à défaut de quoi la
de l'intention de s'adonner au trafic.
gues confèrent aussi un vaste éventail de
organismes d'application de la loi pour
t faire enquête à ce sujet. En vertu de la
nple, les services de police sont autorisés,
ie drogue proscrite, quelle qu'en soit la
ouiller, saisir et remorquer les véhicules
s, à ordonner des fouilles corporelles et à
i sans mandat (art. 18). De plus, lorsqu'il
, les services de police du Queensland
tre d'installer des appareils d'écoute dans

eption) Act 1979 du Commonwealth, les
édéral et dans pratiquement tous les états
s à intercepter les télécommunications
infractions graves liées aux drogues.
tats et les territoires ont pour la plupart
confisquer les bénéfices tirés du crime,
ints et aux narcoproducteurs. Le plus
ne fois la personne condamnée, mais en
fiscation peut être rendue sans qu'il y ait
vaincue que la personne « selon toute
s aux drogues (*Criminal Assets Recovery*

crés en matière de drogues australiens, voir :
s.html.

Décriminalisation du cannabis[189]

Bien que la Stratégie nationale sur
matière de drogues en Australie, les infra
relèvent de la compétence des états et des
ont donc adopté des dispositions visant à d

L'Australie-Méridionale a été la pre
prévoyant des modalités «d'expiation» (
infractions mineures liées au cannabis, co
quantités pour usage personnel ou la p
cannabis. En vertu de cette mesure, les
d'expiation aux adultes coupables d'une
contrevenants peuvent éviter les poursuite
variant entre 50 à 150 $A dans les 60 jo
paiement dans les 60 jours pouvant mener
un casier judiciaire faisant état d'une conda
usagers de cannabis et non à ceux et celles
le produisent. Des peines plus graves
production, à la vente ou à la distribution
et de toutes les substances prohibées, y c
cannabis, ont été adoptées au même mome

Cette mesure a été modifiée par la
aux personnes auxquelles on signifie un
afin de pouvoir contester l'avis. Avant l'e
devaient refuser d'acquitter les frais d
comparaître devant le tribunal et contester
poursuite transforme la présumée infractio
lieu à une condamnation au criminel.

Le Territoire de la capitale de l'Au
respectivement en 1992 et en 1996, des m
œuvre en 1998 un système de mises en ga
infraction mineure liée au cannabis ; un s
après en Australie-Occidentale.

Dans tous les cas, la possession de
La nature de ces dispositions consiste à ré

---

[189] Pour avoir de plus amples détails sur le sujet
dépénalisaton de l'usage de cannabis en Australie
Policy, 21,2, pages 157-186. Disponible en ligne à :
http://www.parl.gc.ca/37/1/parlbus/commbus/

es drogues constitue le cadre général en ions en la matière et les peines connexes rritoires. Certains de ces états et territoires riminaliser l'usage du cannabis.

ière, en 1987, à adopter cette approche *nnabis Expiation Notice* ou CEN) pour les ime la possession ou la culture de faibles session d'accessoires servant à lusage du rvices de police peuvent signifier un avis nfraction mineure liée au cannabis ». Les judiciaires en acquittant les frais indiqués s suivant la signification de l'avis, le non- une poursuite judiciaire et, le cas échéant, à nation. Cette mesure ne s'applique qu'aux qui en font le commerce ou le trafic ou qui our les délits liés à la fabrication, à la toutes les drogues menant à la dépendance npris les délits liés aux fortes quantités de t.

piation of Offences Act, 1996, loi qui permet is d'expiation d'opter pour une poursuite, trée en vigueur de cette loi, ces personnes xpiation avant l'échéance pour pouvoir l'avis. Par contre, le fait d'opter pour une de délit expiable en délit qui peut donner

ralie et le Territoire du Nord ont adopté, ures similaires. L'État de Victoria a mis en le (*cautioning*) à l'intention des auteurs d'une stème similaire a été adopté peu de temps

nnabis demeure une infraction criminelle. ire, le cas échéant, la peine d'incarcération

voir : Single, E., Christie, P., et R. Ali, (2000) « La aux États-Unis : Ses effets », *Journal of Public Health*

nate/Com-f/ille-f/presentation-f/single-f.htm.

qu'entraînait auparavant la possession de petites quantités de cannabis pour son usage personnel.[190]

Diverses études d'évaluation ont été menées depuis, révélant des économies importantes et la diminution des répercussions sociales négatives sur les personnes déclarées coupables d'une infraction mineure liée au cannabis. De même, aucune des études menées en Australie-Méridionale[191] n'a démontré une augmentation de l'usage de cette drogue comme conséquence directe de l'entrée en vigueur du programme CEN. S'il y a eu augmentation de l'usage du cannabis en Australie-Méridionale de 1985 à 1995, il y avait aussi eu augmentation à la grandeur du pays, même dans les États et les Territoires où l'usage du cannabis est totalement interdit : ainsi, la Tasmanie a connu au cours de cette période la plus forte augmentation de consommation hebdomadaire de cannabis en Australie et ce, malgré le fait que la consommation de cannabis y soit prohibée sévèrement.[192]

Une étude comparative des personnes responsables d'infractions mineures liées au cannabis en Australie-Méridionale et en Australie-Occidentale a permis de conclure que ni les mesures d'expiation ni la prohibition n'avaient d'effet dissuasif sur les utilisateurs de cannabis, les contrevenants indiquant qu'un avis d'expiation ou une condamnation n'avaient pas ou pratiquement pas d'incidence sur leur décision de poursuivre leur usage du cannabis ou de consommer une autre drogue. D'autre part, on a constaté que les conséquences sociales négatives d'une condamnation pour un délit lié au cannabis étaient beaucoup plus graves que celles qu'entraînait un avis d'expiation. En effet, la proportion de personnes arrêtées pour usage de cannabis qui ont eu par la suite des problèmes à se trouver un emploi, qui ont eu d'autres démêlés avec l'appareil de justice pénale et qui ont eu des difficultés à se trouver un logement et des difficultés relationnelles, est plus élevée en Australie-Occidentale.[193]

En ce qui concerne l'application de la loi et la justice pénale, le nombre de délits qui ont entraîné la signification d'un avis d'expiation pour usage de cannabis en Australie-Méridionale est passé d'environ 6 000 en 1987-1988 à près de 17 000 en 1993-1994 et durant les années subséquentes. Cela semble être l'expression d'une meilleure efficacité de traitement par les services de police des délits mineurs liés au cannabis et d'une transition graduelle de l'utilisation par les services de police de leur pouvoir discrétionnaire de servir des mises en garde informelles aux contrevenants à un processus d'enregistrement systématique de tous les délits mineurs. On a constaté que

---

[190] Afin d'en savoir plus sur les possibilités légales relatives au cannabis, voir : McDonald *et al.*, *Legislative Options for Cannabis Use in Australia*, *op. cit.*.

[191] Single, Christie, et Ali, *supra*, Nota 3, 11, 12, 18, 19 et 50. Voir aussi Rickard, M., (2001) *Reforming the Old and Refining the New: A Critical Overview of Australian Approaches to Cannabis*, Department of the Parliamentary Library, Information and Research Services, Rapport de recherche n° 6 2001-02, page 29. Disponible en ligne à : http://www.aph.gov.au/library (sous Rapports de recherche).

[192] Rickard, *op. cit.*, page 30.

[193] National Drug Research Institute, Curtin University of Technology, *The Regulation of Cannabis Possession, Use and Supply*, document de travail produit pour le compte du Drugs and Crime Prevention Committee du Parliament of Victoria, Perth, Australie-Occidentale, 2000, p. xxxiv.

le nombre de contrevenants condamnés pour avoir omis d'acquitter les frais d'expiation dans les délais prescrits est important. Cela est dû en grande partie à une méconnaissance chez les usagers de cannabis des conséquences juridiques que peut avoir le non-paiement des frais d'expiation et aux difficultés financières de bon nombre de ceux-ci. Le plus souvent, les CEN s'appliquent à la possession d'une quantité inférieure à 25 g de cannabis et la moitié des CEN sont signifiés à des personnes qui se situent dans le groupe d'âges de 18 à 24 ans.[194]

Cette mesure s'est révélée relativement économique et nettement plus économique que ce qu'aurait été l'interdiction totale de cannabis. On évalue à environ 1,24 million $A le coût total du programme CEN pour 1995-1996, tandis que le total des recettes provenant des frais et des amendes est de l'ordre 1,68 million $ pour le même exercice. On évalue à environ 2,01 millions $A le coût total d'une démarche d'interdiction complète pour l'exercice en question, avec des recettes provenant des amendes de l'ordre de 1 million $.[195]

Un rapport sur le programme CEN[196] constate qu'au-delà des économies pour l'ensemble de la collectivité, ses bénéfices incluent : l'atténuation des conséquences sociales négatives pour les contrevenants, l'amélioration de l'efficacité de traitement des délits mineurs liés au cannabis et l'amélioration des sentiments à l'endroit des policiers. Par contre, la faible proportion de paiement des amendes, qui se situe à environ 45 %, ainsi que l'élargissement du filet de contrôle sont deux faiblesses notables.

Administration

Coûts publics

On évalue à 620 millions $A la somme consacrée en 1992 à la lutte contre les drogues illicites par les gouvernements du Commonwealth, des États et des Territoires. On a consacré 84 % de cette somme, à l'application des lois, 6% au traitement des délinquants et 10 % à la prévention et à la recherche. On évalue à 30 millions $A par année la somme consacrée par le Commonwealth, les États et les Territoires aux programmes d'entretien à la méthadone.

À la lumière d'estimations plus récentes, les gouvernements dépenseraient plus de 200 millions $A par année dans les secteurs de la santé et du bien-être social, comme conséquence directe ou indirecte du commerce des drogues illicites.[197] Il en coûte, semble-t-il, de 450 à 500 millions $A par année à l'appareil de justice pénale pour

---

194 *Ibid.*, page xxxiii.
195 Rickard, *op. cit.*, page 33.
196 Robert Ali et coll., *The Social Impacts of the Cannabis Expiation Notice Scheme in South Australia*, Department of Health and Aged Care, Canberra, mai 1998. Disponible en ligne à : http://www.health.gov.au/pubhlth/publicat/drugs.htm
197 John Broome, « Impacts Upon Social and Political Life », dans *Drugs and Democracy*, *op. cit.*, page 117.

composer avec le problème des drogues illicites.[198] On évalue à plus de 312 millions $A la somme associée chaque année au crime contre les biens de la part des héroïnomanes/trafiquants d'héroïne.[199] Les autorités responsables de l'application des lois évaluent à au moins 2 milliards $A par année le produit de la drogue en Australie. De plus, il semblerait qu'une proportion importante des fonds au montant de quelque 3,5 milliards $A blanchis chaque année en Australie et transitant par l'Australie provient des activités liées aux drogues illicites.[200]

Les coûts économiques afférents à la prévention et au traitement des affections liées à l'usage des drogues, à la baisse de productivité en milieu de travail, au crime, au vol, aux accidents et aux autres activités d'application des lois dépassent les 18 milliards $A par année.[201]

Coûts sociaux

Une étude des conséquences sociales sur les délinquants primaires d'une condamnation pour un délit mineur lié au cannabis a permis de constater que les délinquants en question éprouvaient, dans une faible proportion, une certaine hargne à l'endroit des policiers; on s'est également rendu compte que bon nombre de ces délinquants avaient eu par la suite des problèmes à se trouver un emploi, d'autres démêlés avec la justice, des difficultés à se trouver un logement et des difficultés relationnelles.[202]

En rendant illégale la consommation de cannabis, on oblige les consommateurs à s'approvisionner en cannabis sur le marché clandestin, ce qui les expose à une foule de drogues illicites différentes potentiellement plus dangereuses que le cannabis. Comme autre coût social lié à la drogue, il y a la participation du crime organisé à la production et à la distribution sur une grande échelle. En dernier lieu, le marché clandestin est à l'origine d'une importante économie d'argent liquide. Il ne faut donc pas se surprendre du fait que certains policiers se prêtent à la corruption et se livrent à des activités comme l'usage et le commerce de drogues, la protection de narcotrafiquants, le vol de drogues ou de sommes importantes et la présentation de faux témoignages devant les tribunaux.[203]

---

[198] *Ibid.*, p. 117. Voir également : Sutton A., et S. James, «Law Enforcement and Accountability », in *Drugs and Democracy*, *op. cit.*, page 163, où on cite un montant de 404 millions $A comme coût annuel de l'application des lois sur les drogues illicites dans le Commonwealth, les États et les Territoires.

[199] Broome, *op. cit.*, page 117.

[200] *Ibid.*, page 118.

[201] Ce montant comprend les coûts afférents à l'usage de l'alcool et du tabac. Voir Rohl, T., « Evaluating the National Drug Strategy », dans *Drugs and Democracy*, *op. cit.*, page 134.

[202] The Regulation of Cannabis Possession, Use and Supply, *op. cit.* page 40.

[203] *Ibid.*, pages 40-43.

Statistiques

Consommation[204]

L'*Australian Institute of Health and Welfare* procède tous les 2-3 ans à une enquête sur la consommation des drogues « *National Drug Strategy Household Survey* (NDSHS) ». La première a été menée en 1985 et la septième en 2001. Lors de la dernière enquête dont on possède les résultats (1998)[205] 10 300 Australiens de 14 ans ont été interrogés sur leurs connaissances et opinions sur la consommation de drogues, leurs habitudes de consommation de drogues et des comportements connexes.

Les résultats de cette enquête indiquent que près de 46 % des Australien(ne)s ont déjà consommé des drogues illicites, 23 % au cours des 12 derniers mois. Le cannabis est la drogues de choix (39,1 % des personnes de 14 ans et plus en ayant déjà consommé et 17,9 % de ces personnes en ayant fait usage récemment). Près de la moitié des personnes qui avaient déjà fait usage de cannabis en avaient consommé durant les 12 derniers mois. Près de 11,5 % des répondants ont indiqué avoir déjà consommé des drogues antidouleur/des analgésiques (dans un but non médical); suivent ensuite les hallucinogènes (9,9 %) et les amphétamines (8,8 %). Seulement 2,2 % de la population australienne a déjà consommé de l'héroïne, 0,8 % indiquant un usage récent. La prévalence de la consommation de cocaïne était légèrement plus élevée, près de 4,3 % des répondants ayant déjà fait usage de cette drogue, 1,4 % indiquant une consommation récente.

La deuxième enquête à l'échelle nationale sur l'usage de substances illicites chez les élèves du secondaire a eu lieu en 1999. L'enquête portait sur 25 480 jeunes de 12 à 17 ans de 434 écoles secondaires réparties à la grandeur du pays. Les résultats indiquent que la consommation augmente avec l'âge pour toutes les substances, à l'exception des substances inhalées et des stéroïdes. Quel que soit l'âge, ce sont les analgésiques qu'on consomme le plus (comme médicaments ou non), au moins 95 % des répondant(e)s ayant déjà consommé ce type de substance. La consommation de cannabis est relativement élevée, notamment chez les jeunes de 16 et 17 ans, ceux-ci en consommant davantage que la population en général (47 % contre 39 %). Le nombre de garçons (32 %) ayant déjà fait usage de marijuana était légèrement plus élevé que le nombre de filles (29 %), tandis que c'était le contraire en ce qui concerne les analgésiques (98 % chez les filles contre 96 % chez les garçons). Exception faite de ces deux substances, les pourcentages de consommation antérieure et de consommation récente étaient pratiquement les mêmes pour les filles et les garçons.

---

[204] Miller, M., et G. Draper, (2001) *Statistics on Drug Use in Australia 2000*, Australian Institute of Health and Welfare, Canberra, mai. Disponible en ligne à :http://www.aihw.gov.au/publications/phe/sdua00/index.html

[205] Pour avoir les résultants détaillés de l'enquête NDSHS de 1998, voir : Adhikari, P. et A. Summerill, (2000) *1998 National Drug Strategy Household Survey: Detailed Findings*, Australian Institute of Health and Welfare (Drug Statistics Series No. 6), Canberra, octobre. Disponible en ligne à :http://www.aihw.gov.au/publications/health/ndshs98d/index.html

Infractions[206]

Le cannabis est à l'origine de la majorité des arrestations liées à des infractions en matière de drogues en Australie ; en effet, les arrestations effectuées en raison d'infractions liées à cette drogue comptent, en 1998-1999, pour 70 % de toutes celles qui ont été faites en matière de drogues illicites. Toutefois, durant la période 1995-1996 à 1998-1999 le nombre de personnes arrêtées pour possession ou fourniture de marijuana a fortement diminué (de près de 79 000 à environ 58 000).

L'infraction de trafic de drogue est celle qui est le plus souvent à l'origine des peines d'emprisonnement. Des 1 663 personnes en prison en 1999 pour des infractions liées aux drogues, 78 % ont été condamnées pour des infractions de trafic/de commerce de drogues tandis que 11 % l'ont été pour des infractions de possession ou d'usage de drogues illicites. Le nombre de personnes emprisonnées pour avoir commis des infractions liées aux drogues a diminué entre 1995 et 1999 ; en effet, il comptait pour 11 % de la population carcérale en 1995 et pour 9% de celle-ci en 1999. La proportion de personnes emprisonnées pour possession/usage de drogues n'a pratiquement pas varié (1 %) au cours des cinq dernières années, tandis que la proportion de personnes emprisonnées pour des raisons de commerce/de trafic et de fabrication/de culture de drogues diminue constamment.

Attitudes à l'égard de l'usage de drogues et de la législation afférente

Les résultats de l'enquête NDSHS de 1998 ont permis de constater que les répondants s'opposaient, en grande majorité, à l'usage courant de drogues illicites. Les hommes étaient généralement plus tolérants que les femmes. La marijuana est la drogue illicite dont la consommation est jugée la plus acceptable, 30,5 % des hommes et 20,6 % des femmes se déclarant ouvert(e)s à son usage courant.

L'appui à la légalisation des drogues illicites est sensiblement le même que celui de l'acceptabilité de l'usage courant de ces drogues : 33,8 % des hommes et 25,1 % des femmes se sont déclaré(e)s en faveur de la légalisation de la marijuana. En revanche, seulement 7 % des hommes et 5,1 % se sont déclaré(e)s en faveur de la légalisation de la cocaïne. Les personnes qui appuient la légalisation de l'héroïne, des amphétamines et de la cocaïne se situent, en général, dans les groupes d'âges de 20 à 29 ans et de 40 à 49 ans.

---

[206] Miller et Draper, *op. cit.*, pages 53-58.

LES ÉTATS-UNIS[207]

Décrire adéquatement les politiques, et plus encore les pratiques aux États-Unis, en matière de drogues illicites pourrait faire l'objet d'un rapport en soi. Qu'on en juge : le budget de recherche du seul NIDA s'élève à 1 milliard $ US, représentant environ 85 % des sommes consacrées mondialement à la recherche sur les drogues illicites ; le budget du *Office for National Drug Control Policy* est de plus de 18 milliards $ US, quand le budget de la Stratégie canadienne sur les drogues est de … 16 millions $ canadiens, environ un demi de un p cent du budget du bureau américain ; les dépenses totales en matière de drogues illicites seraient de l'ordre de 35 milliards $ US. Quand on sait en plus la complexité du système politique américain et la diversité de sa population, on n'a guère besoin d'en ajouter sur l'ampleur de la tâche.

Qui plus est, parler des États-Unis et de drogues illicites c'est parler d'un couple indissociable. Nous l'avons vu au chapitre précédent, les USA ont joué, et continuent de jouer, un rôle prépondérant dans la négociation et l'application des conventions internationales sur les drogues. Penser aux drogues quand il est question des USA c'est penser automatiquement à la « guerre à la drogue » et sa cohorte de statistiques sur le recours à l'incarcération, les sentences sévères, les coûts économiques et sociaux faramineux qui en découlent.

Nous ne pourrons, dans cette section, qu'effleurer cette complexité. Nous avons fort heureusement déjà discuté au cours de précédents chapitres, de diverses données sur les USA : taux de consommation au chapitre 6, recherches sur les effets au chapitre 7 par exemple. Notre tâche était encore plus difficile que nous n'avons pu entendre en audiences publiques les représentants de l'administration. Lors de notre journée d'audiences sur les États-Unis, nous avons entendu le Gouverneur du Nouveau-Mexique, monsieur Gary Johnson, et monsieur Ethan Nadelman du *Lindesmith Centre-Drug Policy Foundation.* Ce n'est que le 10 juin 2002 que nous avons pu avoir une rencontre privée avec le directeur du NIDA, M. Hanson, et le 11 juin une rencontre à huis clos avec M. Walters, le directeur de ONDCP.

Le cadre législatif de l'administration fédérale et des États

Traditionnellement, le droit criminel et son application sont en grande partie réservés à la compétence des États. L'article premier de la Constitution des États-Unis énonce les domaines de compétence législative du gouvernement fédéral et le dixième amendement dispose expressément que tous les pouvoirs qui ne sont pas délégués au

---

[207] Cette section s'inspire largement du rapport préparé par la Bibliothèque du parlement pour le Comité spécial : Dolin, B., (2002) *Politique nationale sur les drogues : les États-Unis.* Ottawa : Bibliothèque du Parlement, rapport d'étude préparé pour le Comité spécial du Sénat sur les drogues illicites. Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp

gouvernement central seront exercés par les États. Le droit criminel ne fait pas partie des pouvoirs délégués au gouvernement fédéral et, aux premiers jours du Congrès, les lois pénales fédérales ne régissaient que les actes préjudiciables au gouvernement national, comme la trahison et la contrefaçon, ou les délits de nature extraterritoriale, comme les actes de piraterie et autres crimes perpétrés en haute mer.

Cela n'a toutefois pas empêché le Congrès américain de jouer un rôle de premier plan dans la criminalisation de l'usage des drogues. Même si le « Père de la Constitution », James Madison, avait donné aux États l'assurance que leurs pouvoirs étaient « nombreux et illimités » et ceux du gouvernement central, « peu nombreux et limités »[208], les tribunaux ont par la suite interprété d'une manière très large les pouvoirs du Congrès. Déjà en 1819, dans l'arrêt *McCulloch* c. *Maryland*[209], la Cour suprême des États-Unis faisait une lecture libérale des dispositions de l'article premier selon lesquelles le gouvernement fédéral peut adopter toutes les lois qui sont « nécessaires et convenables » pour exercer les pouvoirs qui lui ont été conférés. Deux de ces pouvoirs sont celui de lever des impôts et celui de réglementer le commerce extérieur et inter-état. Comme nous le précisons plus loin, le gouvernement fédéral a utilisé ces champs de compétence comme point d'ancrage pour s'engager dans la réglementation de l'usage des drogues.

Historique[210]

Entre la guerre de Sécession (1861-1865) et la fin du XIX^e^ siècle, la consommation et la vente d'opium, de morphine, de cocaïne et d'autres drogues psychotropes étaient légales et courantes. L'opium était disponible avec ou sans ordonnance médicale et il entrait dans la composition de nombreux médicaments brevetés, notamment des analgésiques, des préparations contre la toux et des sirops pour soulager les douleurs de la dentition chez les bébés. La cocaïne était également utilisée à des fins médicales et elle entrait dans la préparation de boissons gazeuses et du vin.

Les choses commencèrent à changer au tournant du siècle. L'héroïne, isolée en 1898, était réputée apporter le même soulagement que l'opium ou la morphine, sans risque de dépendance. Lorsqu'on découvrit son effet d'accoutumance peu après sa mise en marché, des appels racistes se faisaient déjà entendre pour protéger la société américaine contre les drogues. À l'origine, deux drogues étaient visées : la cocaïne, associée surtout aux Noirs qui avaient la réputation de s'adonner à la violence lorsqu'ils

---

208 In Currie D.P. (2000) *The Constitution of the United States: A Primer for the People*, Chicago: Univ. of Chicago Press, page 26.

209 17 U.S. 316.

210 Voir : Belenko, S.R. (dir.), (2000 *Drugs and Drug Policy in America: A Documentary History*, Westport: Greenwood Press; McNamara, J.D. (1997) « Commentary: Criminalization of Drug Use » *Psychiatric Times*, vol. XVII(9); Luna, E.G. (1997) « Our Vietnam: The Prohibition Apocalypse », 46 *Depaul L. Rev.* 483. Duke, Stephen B., (1995) « Commentary: Drug Prohibition: An Unnatural Disaster », 27 Conn. L. Rev. 571).

étaient sous son influence, et l'opium, associé aux Chinois qui fréquentaient les fumeries. Les sociétés de tempérance et les groupes religieux ont également joué un rôle prépondérant dans les pressions en faveur de la prohibition.

Malgré la forte opposition de l'industrie des médicaments brevetés, le Congrès américain adopta, en 1906, la *Pure Food and Drug Act.* Cette loi obligeait les fabricants de médicaments sans ordonnance à indiquer la quantité de drogues contenues dans ces médicaments, et ce, afin d'en freiner la consommation. Peu après, le Congrès a adopté le *Opium Smoking Act* de 1909 *(as Amended,* 1914*)* qui interdisait l'importation de cette drogue à des fins non médicales.

La Harrison Narcotic Act de 1914

La *Harrison Act* marque une étape importante de la politique américaine de lutte contre les stupéfiants. Adoptée en 1914, la *Harrison Act* visait au début à médicaliser la cocaïne et l'héroïne en limitant leur distribution aux seuls médecins, mais son objet officiel a vite été modifié sous l'influence de la ferveur prohibitionniste de l'époque et est devenu le modèle insolite auquel allait obéir l'administration de la politique américaine en matière de stupéfiants. En vertu des limites constitutionnelles telles qu'elles étaient perçues à l'époque, les lois fédérales s'appliquaient uniquement aux contrôles internationaux, au commerce entre les États et aux impôts. Par conséquent, la *Harrison Act* s'attaqua à l'usage des drogues en obligeant les vendeurs de drogues à obtenir un permis et à consigner toutes leurs ventes, soi-disant aux fins d'imposition. Cette même réglementation obligeait les consommateurs de drogues à obtenir une ordonnance. Même si la loi autorisait expressément les médecins à prescrire des stupéfiants, ils ne pouvaient le faire que dans l'exercice de leur profession.

Contestée devant les tribunaux, la validité de cette loi a été confirmée par la Cour suprême en tant que mesure fiscale et non en tant que mesure de maintien de l'ordre.[211] Le tribunal avait jugé que la loi n'autorisait pas les médecins à prescrire des drogues à des toxicomanes dans le but de les soulager ou d'entretenir leur dépendance.[212] L'arrêt *Behrman*[213], rendu en 1922, vint restreindre davantage le pouvoir des médecins de prescrire des drogues et, dans la foulée des poursuites intentées contre les pharmaciens et les médecins, il devint presque impossible, au début des années 20, de se procurer légalement des opiacés et d'autres drogues.

Les mesures ultérieures

Durant la Grande Dépression, les craintes soulevées par les « Mexicains dégénérés » qui fumaient de la marijuana entraînèrent également l'adoption d'une mesure législative. Certains observateurs y voient là le fil conducteur de la politique antidrogues américaine ; autrement dit, le facteur sur lequel on s'appuyait pour décider

---

[211] *United States* c. *Doremus* (1919), 249 U.S. Reports 86. L'arrêt *United States* c. *Nigro* (1928), 276 U.S. Reports 332, a confirmé que la *Harrison Act* était une loi fiscale.

[212] *Webb et al.* c. *United States* (1919), 249 U.S. Reports 96.

[213] *United States* c. *Behrmann* (1922), 258 U.S. Reports 280.

s'il fallait criminaliser ou non une drogue particulière n'était ni ses propriétés inhérentes ni son potentiel de nuire à la société, mais plutôt le genre de personnes qui en faisaient usage.[214] En 1931, la consommation de marijuana était interdite dans 29 États et en 1937, le Congrès adopta la *Marihuana Tax Act* qui, à l'instar de la *Harrison Act*, conférait au gouvernement fédéral le pouvoir de contrôler la marijuana, en vertu du pouvoir de taxation du Congrès. Malgré l'opposition de l'Association médicale américaine, la loi reçut l'appui du chef de la police antidrogues du pays, le puissant directeur du *Federal Bureau of Narcotics* (FBN), Henry J. Anslinger.

Anslinger, un personnage clé dans l'histoire de la politique américaine de lutte contre les stupéfiants, fut nommé commissaire du FBN en 1930 et il dirigea cette organisation durant cinq administrations présidentielles, soit jusqu'en 1962. Souvent comparé à son contemporain J. Edgar Hoover qui dirigeait le F.B.I. avec autant de ténacité, Anslinger s'opposait à l'adoption d'une approche axée sur la santé publique, soutenant que la seule solution valable consistait à envoyer les consommateurs de drogues en prison. À maintes reprises, il laissa entendre que les stupéfiants faisaient partie d'un complot ourdi par les étrangers. Pendant la Seconde Guerre mondiale, il accusa les Japonais d'utiliser les stupéfiants pour miner l'ardeur des Américains au combat ; après la guerre, il soutenait que les Communistes essayaient de faire la même chose.

La législation actuelle et son application

La loi fédérale

La Controlled Substances Act

En 1970, le Congrès américain adopta la *Controlled Substances Act* (*CSA*)[215], en vertu du pouvoir du gouvernement fédéral de réglementer le commerce entre les États.[216] Cette loi abrogeait la plupart des lois fédérales antérieures, dont la *Harrison Act* et la *Marihuana Tax Act*, et elle constitue la pierre angulaire de la loi fédérale américaine actuelle en matière de stupéfiants. Les drogues y sont classées selon une série d'annexes et contrôlées à des degrés divers. La plupart des restrictions frappent les drogues classées dans l'annexe I dont la possession est interdite, sauf aux fins de recherches pour lesquelles un permis est accordé par le gouvernement fédéral. L'annexe I comprend des drogues comme la marijuana, l'héroïne, la MDMA, le LSD et le peyotl, drogues réputées n'avoir aucun usage médical et présentant un potentiel élevé

---

[214] Luna, *op. cit.*, page 490-495.

[215] Comprehensive Drug Abuse Prevention and Control Act of 1970, Title II, 21 U.S.C. sec. 800-966.

[216] Pour prescrire des sanctions pénales, il suffit au Congrès de prouver qu'une catégorie d'activités nuit au commerce entre les États ; il n'est pas tenu de prouver que la conduite faisant l'objet de la poursuite a des conséquences sur le commerce. Voir Ehrlich, S. (2000) « The Increasing Federalization of Crime » 32 *Ariz. St.L.J.*825.

d'abus. Les substances de l'annexe II, utilisées à une fin médicale reconnue et réputées présenter un potentiel d'abus moins élevé que celles de l'annexe I, sont également soumises à des contrôles sévères. L'annexe II comprend la cocaïne, l'opium, la morphine, la mépéridine (démérol) et la codéine.

L'adoption de la CSA en 1970 marquait un changement important sur un point essentiel. Cette loi établissait une distinction entre la marijuana et les autres drogues et réduisait les sanctions fédérales, non seulement dans les cas de possession, mais également de trafic et de distribution. Cette situation allait toutefois changer sous l'administration Reagan, dans les années 80.

En 1982, le président Reagan signa un décret portant création du poste de conseiller de la Maison blanche en matière de politique antidrogues. La *Comprehensive Crime Control Act of 1984*, la *Anti-Drug Abuse Act of 1986* et la *Anti-Drug Abuse Amendment Act of 1988* renforçaient les sanctions fédérales applicables à divers délits liés aux stupéfiants (notamment à la marijuana), accroissant le financement des activités de lutte contre les stupéfiants et améliorant la coordination des efforts du gouvernement fédéral dans sa lutte contre les stupéfiants. La *National Narcotics Leadership Act* de 1988 créa *l'Office of National Drug Control Policy* (le Bureau de la politique nationale de lutte contre les stupéfiants), dont le directeur est couramment appelé le « tsar de la drogue ».[217]

De nombreux commentateurs ont fait valoir que ces lois ont été adoptées à une époque à laquelle sévissait une hystérie antidrogues extrêmement virulente causée par l'apparition de la cocaïne épurée (crack).[218] C'est probablement aux mythes propagés par les politiciens et véhiculés par les médias sur la cocaïne épurée que l'on doit pour une bonne part le recours accru aux peines minimales obligatoires et l'expansion qu'a connue la « guerre aux drogues » pendant l'ère Reagan.

Classement des drogues en vertu de la CSA – l'exemple de la marijuana

L'examen d'une demande adressée à la Drug Enforcement Administration en 2000 visant le reclassement de la marijuana permet de comprendre le processus de classement des drogues suivant les annexes de la CSA[219] Pour conclure que la marijuana devait demeurer dans l'annexe I, le département de la Justice s'est appuyé sur huit facteurs :

- Le potentiel réel ou relatif d'abus de la drogue ;
- Les preuves scientifiques de ses effets pharmacologiques ;
- L'état actuel des connaissances scientifiques concernant la drogue ;

---

[217] La page d'accueil du Bureau se trouve à www.whitehousedrugpolicy.gov.

[218] Voir, par exemple, Reinarman, C. et H. G. Levine (dir.), *Crack in America: Demon Drugs and Social Justice*, University of California Press, 1997. Dans un rapport sur les États-Unis publié en mai 2000, l'organisme Human Rights Watch a qualifié le phénomène de « panique morale ». Disponible en ligne à www.hrw.org/reports/2000/usa.

[219] Département de la Justice, Drug Enforcement Agency, « Notice: Denial of Petition », 18 avril 2001 dans le vol. 66, nº 75 du registre fédéral, pages 20037-20076.

- Son historique et les abus actuels ;
- L'étendue, la durée et l'importance de l'abus ;
- Les risques pour la santé publique, s'il y a lieu ;
- Les risques de dépendance psychique et physiologique ; et
- S'il s'agit d'un précurseur immédiat d'une substance déjà contrôlée en vertu de la CSA.

La demande de reclassement fut rejetée en partie au motif que la marijuana présentait un potentiel élevé d'abus. Bien que le terme « abus » ne soit pas défini dans la loi, l'Administration s'est penchée sur divers facteurs pour évaluer le potentiel d'abus. Elle a constaté en particulier que les usagers consomment cette substance en quantités suffisantes pour constituer une menace pour leur santé ou la sécurité d'autrui ou de la collectivité. L'Administration a conclu que, même si la marijuana présentait un faible niveau de toxicité comparativement à d'autres drogues dont on abuse, sa consommation tant aiguë que chronique entraînait un certain nombre de risques tels que des étourdissements, des nausées, des distorsions temporelles, des erreurs de jugement et des pertes de mémoire à court terme. Elle a également cité des études décrivant le «syndrome de sevrage de la marijuana » caractérisé par l'hyperactivité, l'agitation, l'insomnie, des nausées et des crampes qui durent pendant quelques jours.

Un autre élément important de l'analyse qui militait contre le reclassement de la marijuana était le fait que cette drogue n'avait pas d'usage médical reconnu aux États-Unis. Aucun traitement à base de marijuana n'a encore été autorisé par la *Food and Drug Administration*. Pour que le traitement soit autorisé, les conditions suivantes doivent être réunies :

- La composition chimique de la drogue doit être connue et reproductible ;
- La drogue doit avoir fait l'objet d'un nombre suffisant d'études de sécurité ;
- La drogue doit avoir fait l'objet d'un nombre suffisant d'études bien contrôlées prouvant son efficacité ;
- La drogue doit être approuvée par des spécialistes compétents ; et
- La preuve scientifique doit être mise à la disposition du grand public.

La législation proposée

La bataille législative au sujet des drogues se poursuit encore devant le Congrès américain. Le projet de loi *Drug Dealer Liability Act* de 1999 a été approuvé par la Chambre des représentants et envoyé au Sénat à la fin de l'an 2000. Cette mesure législative imposerait une responsabilité civile aux trafiquants de drogues pour les dommages découlant – directement ou indirectement – de la consommation de substances contrôlées. Elle autoriserait même les consommateurs de drogues à intenter des poursuites pour les dommages subis, à condition qu'ils divulguent aux agents de lutte contre les stupéfiants tout ce qu'ils savent sur la source de la drogue illicite. Même

si on ne sait pas encore si ce projet de loi sera adopté, treize États ont déjà adopté une loi sur le modèle de la *Drug Dealer Liability Act.*[220]

Le 17 octobre 2000, la Chambre des représentants approuvait la *Protecting Our Children from Drugs Act* de 2000. Cette loi modifierait la *Controlled Substances Act* en imposant des sanctions plus sévères aux trafiquants de drogues qui font appel à des enfants pour leur trafic. Les peines obligatoires minimales seraient plus sévères pour les trafiquants qui utilisent des enfants de moins de 18 ans pour distribuer de la drogue à l'intérieur ou à proximité des écoles ou d'autres « lieux protégés » comme les terrains de jeu et les arcades de jeux vidéos. D'autres projets de loi sont à l'étude, notamment la *Drug Free America Act* de 2001, la *Domestic Narcotic Demand Reduction Act* de 2001 et la *Drug Treatment and Research Enhancement Act de* 2001.

Les sanctions fédérales

Les tableaux suivants résument les amendes et les peines d'emprisonnement prévues pour certaines infractions à la *Controlled Substances Act* et à d'autres lois fédérales connexes[221]. Il est à noter que dans le cas d'un troisième délit grave (« felony ») impliquant des quantités constituant un délit du premier degré, une peine d'emprisonnement à perpétuité s'applique, sans possibilité de libération. Il est également à noter que les poids indiqués, sans égard à la substance utilisée, se rapportent à tout mélange renfermant une quantité décelable d'une drogue illicite. Les délits de complot et de « tentative » entraînent les mêmes peines que l'infraction elle-même.

---

[220] L'Arkansas, la Californie, le Colorado, la Géorgie, Hawaii, l'Illinois, l'Indiana, la Louisiane, le Michigan, l'Oklahoma, la Caroline du Sud, le Dakota du Sud, l'Utah et les îles Vierges américaines.

[221] Le Congrès a adopté divers projets de loi contre le crime comportant des dispositions antidrogues, notamment la *Crime Control Act* de 1984 (P.L. 98-473), la *Anti-Drug Abuse Act* de 1986 (P.L. 99-570), la *Anti-Drug Abuse Act* de 1988 (P.L. 100-690), la *Crime Control Act* de 1990 (P.L. 101-647) et la *Violent Crime Control and Law Enforcement Act* de 1994 (P.L. 103-322). Collectivement, ces lois accroissent la sévérité des peines pour des infractions liées aux drogues et augmentent le financement des activités de lutte contre les stupéfiants.

Tableau 1[222]

Distribution, possession dans l'intention de distribuer, fabrication, Importation et exportation illicites				
Substance	Infraction/ récidive	Quantité	Amende (en dollars)	Peine d'emprisonnement
Héroïne	Première infraction	1 kg ou plus	4 à 10 millions	de 10 ans à la détention à perpétuité
		100 g à 1 kg	2 à 5 millions	de 5 à 40 ans
		Moins de 100 g	1 à 5 millions	jusqu'à 20 ans
	Deuxième infraction[223]	1 kg ou plus	8 à 20 millions	de 20 ans à la détention à perpétuité
		100 g à 1 kg	4 à 10 millions	de 10 ans à la détention à perpétuité
		Moins de 100 g	2 à 10 millions	jusqu'à 30 ans
Feuilles de coca, cocaïne ou « crack »	Première infraction	50 g ou plus	4 à 10 millions	de 10 ans à la détention à perpétuité
		5 à 50 g	2 à 5 millions	de 5 à 40 ans
		Moins de 5 g	1 à 5 millions	jusqu'à 20 ans
	Deuxième infraction	50 g ou plus	8 à 20 millions	de 20 ans à la détention à perpétuité
		5 à 50 g	4 à 10 millions	de 10 ans à la détention à perpétuité
		Moins de 5 g	2 à 10 millions	Jusqu'à 30 ans
LSD	Première infraction	10 g ou plus	4 à 10 millions	de 10 ans à la détention à perpétuité
		1 à 10 g	2 à 5 millions	de 5 à 40 ans
		Moins de 10 g	1 à 5 millions	jusqu'à 20 ans
	Deuxième infraction	10 g ou plus	8 à 20 millions	de 20 ans à la détention à perpétuité
		1 à 10 g	4 à 10 millions	de 10 ans à la détention à perpétuité
		Moins de 10 g	2 à 10 millions	Jusqu'à 30 ans
Marijuana	Première infraction	1000 kg ou plus ou 1000 plants ou plus	4 à 10 millions	de 10 ans à la détention à perpétuité

[222] Source : Doyle, C., *Drug Offences: Maximum Fines and Terms of Imprisonment for Violation of the Federal Controlled Substances Act and Related Laws*, Library of Congress Congressional Research Service, 1er novembre 2000.

[223] Par deuxième infraction, on entend une infraction commise après une première condamnation pour *toute* infraction liée à la drogue en vertu de *n'importe quelle* loi antidrogues du gouvernement fédéral, d'un État ou d'un pays étranger.

Distribution, possession dans l'intention de distribuer, fabrication, Importation et exportation illicites				
Substance	Infraction/ récidive	Quantité	Amende (en dollars)	Peine d'emprisonnement
		100 à 1000 kg ou 100 à 1000 plants	2 à 5 millions	de 5 à 40 ans
		50 à 100 kg ou 100 plants	1 à 5 millions	Jusqu'à 20 ans
		Moins de 50 kg[224]	250 000 à 1 million	Jusqu'à 5 ans
	Deuxième infraction	1000 kg ou plus ou 1000 plants ou plus	8 à 20 millions	de 20 ans à la détention à perpétuité
		100 à 1000 kg ou 100 à 1000 plants	4 à 10 millions	de 10 ans à la détention à perpétuité
		50 à100 kg ou 100 plants	2 à 10 millions	jusqu'à 30 ans
		Moins de 50 kg	500 000 à 2 millions	jusqu'à 10 ans

Tableau 2

Simple possession				
Drogue	Infraction/ récidive	Quantité	Amende (en dollars)	Peine d'emprisonnement
À base de cocaïne	Première	Plus de 5 g	Jusqu'à 250 000	de 5 à 20 ans
	Première	5 g ou moins	1 000 minimum	jusqu'à 1 an
Toutes les autres drogues	Première	N'importe quelle quantité		
À base de cocaïne	Deuxième[225]	Plus de 3 g	Jusqu'à 250 000	de 5 à 20 ans
Toutes les autres drogues	Deuxième	N'importe quelle quantité	2 500 minimum	de 15 jours à 2 ans
À base de cocaïne	Troisième	Plus de 1 g	Jusqu'à 250 000	de 5 à 20 ans
Toutes les autres drogues	Troisième	N'importe quelle quantité	5 000 minimum	de 90 jours à 3 ans

[224] La distribution d'une petite quantité de marijuana sans rémunération est traitée comme une simple possession et les peines applicables sont résumées dans le deuxième tableau.

[225] Par condamnation antérieure, on entend une condamnation pour *toute* infraction prévue à la *Controlled Substances Act* ou dans toute loi antidrogues d'un État.

Lois en vigueur dans les États

Généralités

Aux États-Unis, un groupe appelé *National Conference of Commissioners on Uniform State Law* a le mandat d'élaborer des lois que tous les États seront encouragés à adopter en vue de promouvoir l'uniformisation législative dans le pays. La plus récente *Uniform Controlled Substances Act* date de 1994. Cette loi définit en détail les activités illicites, mais elle laisse la détermination des amendes et des peines à la discrétion de chaque État. La plupart des États ont adopté les principales dispositions de la *Uniform Act*[226], à l'exception du New Hampshire et du Vermont, où les lois en vigueur ne sont pas calquées sur la *Uniform CSA*, bien qu'elles contiennent certaines dispositions similaires et visent le même objectif général. Il importe également de signaler certaines exemptions relatives à l'utilisation de la marijuana à des fins médicales, dont il sera question plus loin.

En ce qui a trait à la détermination des peines, il existe de grandes différences entre les États.[227] En ce qui concerne les infractions relatives à d'autres drogues, certains États appliquent des peines extrêmement sévères. D'autres États qui appliquent des peines aussi sévères sont en train de réviser les peines obligatoires minimales, souvent pour des raisons d'ordre fiscal. Par exemple, l'assemblée législative de la Louisiane a remanié ses lois antidrogues en juin 2001. La nouvelle législation prévoit des peines réduites pour les infractions liées aux drogues et abroge les peines obligatoires minimales imposées pour de nombreux crimes non violents. Comme l'a dit un législateur républicain, « cela coûte trop cher d'emprisonner ces gens et de jeter la clé ».

L'usage médical de la marijuana

Depuis 1978, 35 États ont promulgué des lois relatives à l'utilisation de la marijuana à des fins médicales. Depuis lors, cinq de ces lois ont expiré ou ont été abrogées, mais les autres sont toujours en vigueur. Parmi les États restants :

- Douze États ont promulgué des lois créant des « programmes de recherche thérapeutique » qui autorisent la recherche scientifique (bien que l'interdiction fédérale en rende l'application complexe).

---

226 La *Uniform Laws Annotated*, Master Edition, volume 9, parties II, III et IV, présente des notes à l'usage des États qui adoptent la loi. Sous la rubrique General Statutory Note, il est dit que les États dont la loi antidrogues s'appuie sur la *Uniform Act* sont considérés comme ayant adopté de façon importante les principales dispositions de la *Uniform Act*, mais que le texte officiel de la loi de l'État s'écarte du texte officiel de telle manière qu'il est impossible d'indiquer avec précision dans les notes statutaires toutes les substitutions, omissions et adjonctions. Pour cette raison, on recommande de consulter la loi de chaque État pour connaître les détails particuliers de chaque CSA. Une autre référence utile est Richard A. Leiter (dir.), *National Survey of State Laws, 3rd Ed.*, Detroit, Gale Group, 1999, qui présente, aux pages 152 à 188 des tableaux des infractions et des peines prévues par tous les États relativement à la cocaïne, à l'héroïne et à la marijuana.

227 L'Annexe 2 du rapport de B. Dolin, *op. cit.*, décline les principales alternatives.

- Dix États (en plus du district fédéral de Columbia) ont promulgué des lois symboliques qui, tout en reconnaissant la valeur médicale potentielle de la marijuana, n'offrent aucune protection contre les arrestations.
- Huit États ont adopté des lois qui autorisent les patients à consommer de la marijuana à des fins médicales malgré l'interdiction fédérale.

Le tableau suivant résume la situation dans les huit États qui ont adopté de telles lois autorisant l'utilisation de marijuana à des fins médicales. Même si la possession de marijuana demeure un crime fédéral, la plupart des arrestations liées à la drogue sont effectuées par la police de l'État ou la police locale. Comme le gouvernement fédéral ne peut forcer ces corps policiers à appliquer les lois fédérales, les consommateurs de marijuana à des fins médicales parviennent généralement à échapper aux poursuites dans ces États. Cependant, comme la marijuana n'est pas vendue en pharmacie, certains centres de distribution, appelés « clubs d'acheteurs », ont vu le jour, mais ils se sont butés à la loi fédérale.

La Cour suprême s'est récemment penchée sur le cas des «clubs d'acheteurs » dans l'affaire *Conant* c. *Oakland Cannabis Buyers' Cooperative.*[228] La Cour a statué à l'unanimité qu'on ne pouvait plaider la nécessité médicale pour se soustraire aux interdictions relatives à la fabrication et à la distribution de marijuana prévues à la *Controlled Substances Act.* Comme cette drogue est classée dans l'annexe 1 de la CSA, elle est considérée comme n'ayant pas d'usage médical. Bien que l'arrêt *Conant* ne rende pas inopérantes les lois des États concernant l'usage thérapeutique de la marijuana, il accroît néanmoins le pouvoir fédéral d'intenter des poursuites en vertu de la CSA dans tous les États. Cela dit, les efforts du gouvernement fédéral pour appliquer la loi n'ont jamais visé, jusqu'à maintenant, les personnes qui possèdent ou cultivent de petites quantités à des fins thérapeutiques. Ils ne visaient que les « clubs d'acheteurs » (également appelés « club compassion »).

Au sujet du tableau suivant, il est à noter que la qualité de marijuana qu'un patient peut posséder varie d'un État à l'autre, de même que les dispositions qui dégagent les soignants de toute responsabilité criminelle.

État et date de promulgation	Protection offerte aux patients	Documentation requise

[228] N° 00-151. Entendue le 28 mars 2001 – Décision rendue le 14 mai 2001. Citée sous : 532 U.S. __ (2001).

État et date de promulgation	Protection offerte aux patients	Documentation requise
Alaska – le 3 nov. 1998	Défense affirmative[229] assurée aux patients inscrits auprès de l'État	Attestation signée par le médecin confirmant que le patient a été examiné, qu'il souffre d'une maladie débilitante et que d'autres médicaments ont été envisagés.
Californie – le 5 nov. 1996	Pas de poursuite lorsque le patient possède ou cultive de la marijuana uniquement à ses propres fins thérapeutiques.	Approbation écrite ou verbale du médecin qui a jugé que la marijuana pouvait être bénéfique pour la santé du patient dans le traitement d'une maladie reconnue.
Colorado – le 7 nov. 2000	Pas de poursuite lorsque le patient détient une fiche d'inscription; défense affirmative lorsqu'il ne détient pas de fiche mais qu'il se conforme aux exigences de la loi.	La maladie débilitante a été diagnostiquée avant l'arrestation du patient et celui-ci a obtenu une recommandation d'un médecin attestant que la marijuana pourrait le soulager.
Hawaii – le 14 juin 2000	Pas de poursuite lorsque le patient détient une fiche d'inscription; la défense *choice of evils* (choix entre deux maux) est également autorisée[230].	Fiche obtenue sur présentation du dossier médical ou attestation d'un médecin que le patient souffre d'une maladie débilitante et que les bienfaits de la marijuana peuvent vraisemblablement compenser les risques pour la santé .
Maine – le 2 nov. 1999	L'État a le fardeau de prouver que l'usage de la drogue à des fins thérapeutiques par le patient n'est pas autorisé par la loi.	Dossier médical ou lettre d'un médecin attestant que le patient souffre d'une maladie reconnue, qu'il a informé le patient des risques et que le patient pourrait être soulagé par l'utilisation thérapeutique de la marijuana.
Nevada – le 7 nov. 2000	Pas de poursuite.	« Recommandation requise »; le législateur n'a pas encore précisé les modalités.
Oregon – le 3 nov. 1998	Pas de poursuite lorsque le patient détient une fiche d'inscription; défense affirmative lorsque le défendeur ne possède pas de fiche mais qu'il se conforme à la loi; défense *choice of evils*	La maladie débilitante a été diagnostiquée dans les 12 mois précédant l'arrestation du patient et celui-ci a obtenu une recommandation du médecin attestant que la marijuana pourrait atténuer les symptômes

229 Une « défense affirmative » exige que le défendeur prouve selon toute probabilité qu'il ne déroge pas à la loi.

230 La défense *choice of evils* (choix entre deux maux) désigne la défense fondée sur la nécessité médicale. Reconnue depuis longtemps par la common law, ce moyen de défense permet à un défendeur de prouver au tribunal, dans le cas de l'utilisation de la marijuana à des fins médicales, que son infraction à la loi s'avérait nécessaire pour éviter un plus grand mal, soit la douleur causée par la maladie débilitante. Certains États, comme on peut le voir dans le tableau, ont codifié ce moyen de défense.

État et date de promulgation	Protection offerte aux patients	Documentation requise
		ou les effets de la maladie.
Washington – le 3 nov. 1998	Pas de poursuite lorsque le patient est admissible, ne possède pas une quantité de marijuana supérieure à celle nécessaire pour son traitement et présente les documents valides requis par la loi; défense affirmative lorsqu'il est en conformité avec la loi.	Attestation signée par le médecin ou dossier médical indiquant que le médecin est d'avis que les « bienfaits potentiels » de la marijuana pourraient être supérieurs aux risques pour la santé.

Buts et objectifs de la politique fédérale de lutte contre les stupéfiants

Les buts de la politique nationale de lutte contre les stupéfiants des États-Unis, tels qu'énoncés, sont la prévention, l'éducation, le traitement et la recherche, complétés par des activités de « réduction de l'offre »[231]. Dans le rapport annuel 2001 du Bureau de la politique nationale de lutte contre les stupéfiants (ONDCP), on peut lire ce qui suit :

> [Traduction] *« Au moyen d'un éventail équilibré de mesures visant à réduire la demande et l'offre, notre objectif est de réduire de moitié, d'ici 2007, la disponibilité et l'abus de drogues et d'au moins 25 % les conséquences de l'abus. »* [232]

En comparant le problème de la drogue au cancer, l'ONDCP énumère les buts et les objectifs stratégiques suivants comme étant au cœur de l'intervention du gouvernement fédéral dans ce domaine.[233]

But 1: Éduquer les jeunes Américains et leur donner les moyens de rejeter les drogues illicites de même que l'alcool et le tabac.

Objectif 1 : Éduquer les parents et autres aidants naturels, les enseignants, les entraîneurs, les membres du clergé, les professionnels de la santé, les dirigeants du milieu des affaires et de la collectivité afin qu'ils aident les jeunes à rejeter les drogues illicites et à renoncer à la consommation d'alcool et de tabac avant l'âge légal.

Objectif 2 : Mettre en œuvre un vigoureux programme de publicité et de communication pour faire connaître les dangers de la consommation de drogues illicites, d'alcool et de tabac chez les jeunes.

Objectif 3 : Promouvoir des politiques de tolérance zéro à l'égard des jeunes qui consomment des

231 *National Drug Control Strategy: 2001 Annual Report*, Office of National Drug Control Policy, page 3.
232 *Ibid.*, page 4.
233 En ligne à l'adresse suivante :
http://www.whitehousedrugpolicy.gov/publications/policy/99ndcs/goals.html.

drogues illicites, de l'alcool et du tabac à la maison, à l'école, au travail et au sein de la collectivité.

Objectif 4 : Mettre en place des programmes et des politiques de prévention fondés sur des recherches à l'intention des élèves de la maternelle à la 12e année afin de prévenir la consommation d'alcool, de tabac et de drogues illicites.

Objectif 5 : Aider les parents et les mentors adultes à encourager les jeunes à adopter un mode de vie positif et sain et à leur servir de modèles.

Objectif 6 : Encourager et faciliter la création de coalitions et de programmes communautaires visant à prévenir l'usage de drogues ainsi que la consommation d'alcool et de tabac chez les mineurs.

Objectif 7 : Créer des partenariats avec les médias, l'industrie des loisirs et les associations sportives professionnelles dans le but de prévenir l'idéalisation, la tolérance ou la banalisation des drogues illicites et de la consommation d'alcool et de cigarettes par les jeunes.

Objectif 8 : Élaborer et appliquer une série de principes étayés par la recherche pouvant servir de point de départ à l'élaboration d'un programme de prévention.

Objectif 9 : Soutenir et valoriser la recherche, notamment la production de données scientifiques, dans le but d'enrichir les programmes de lutte contre les drogues, l'alcool et le tabac à l'intention des jeunes.

But 2 : Accroître la sécurité des Américains en réduisant de manière substantielle les crimes et la violence liés à la drogue.

Objectif 1 : Renforcer l'application de la loi, notamment grâce à des groupes d'intervention antidrogue mandatés par le gouvernement fédéral, les États et les localités pour combattre la violence liée à la drogue, démanteler les organisations criminelles et arrêter et poursuivre en justice les chefs de syndicats de trafiquants.

Objectif 2 : Accroître la capacité des zones de trafic intense de stupéfiants à lutter contre le trafic des stupéfiants.

Objectif 3 : Faciliter l'application des lois afin de démanteler les réseaux de blanchiment d'argent et saisir et confisquer les revenus provenant de la criminalité.

Objectif 4 : Briser le cycle de l'abus de drogues et de la violence.

Objectif 5 : Soutenir et valoriser la recherche, notamment la production de connaissances et de données scientifiques, dans le but de faciliter l'application de la loi ainsi que la poursuite, l'incarcération et le traitement des contrevenants impliqués dans des affaires de drogues illicites.

But 3 : Réduire les coûts de santé et les coûts sociaux engendrés par la consommation de drogues illicites.

Objectif 1 : Soutenir et promouvoir le traitement efficace, efficient et accessible des toxicomanes par la mise en place d'un système adapté aux nouvelles tendances en matière de toxicomanie.

Objectif 2 : Réduire les problèmes de santé liés à la drogue, en particulier les maladies infectieuses.

Objectif 3 : Promouvoir l'adoption nationale de programmes sans drogue en milieu de travail, particulièrement d'un programme général comprenant les volets suivants : tests de dépistage de drogues, éducation, prévention et intervention.

Objectif 4 : Soutenir et promouvoir l'éducation, la formation et la certification de professionnels travaillant auprès de toxicomanes.

Objectif 5 : Soutenir la recherche visant la mise au point de médicaments et de protocoles connexes pour prévenir ou réduire la dépendance aux drogues et leur consommation.

Objectif 6 : Soutenir et valoriser la recherche et la technologie, notamment la collecte et l'analyse de données scientifiques, afin de réduire les coûts sociaux et les coûts de santé engendrés par la consommation de drogues illicites.

Objective 7: Soutenir la recherche scientifique sur les conséquences de la légalisation des drogues et en diffuser les résultats et les données pertinentes.

But 4 : Protéger les frontières aériennes, terrestres et maritimes des États-Unis contre la menace des stupéfiants.

Objectif 1 : Mener des opérations adaptées au contexte visant à localiser, démanteler, détourner et saisir les drogues illicites qui transitent vers les États-Unis et aux frontières du pays.

Objectif 2 : Améliorer la coordination et l'efficacité des programmes américains d'application de la loi en mettant l'accent sur la frontière sud-ouest, Porto Rico et les îles Vierges américaines.

Objectif 3 : Accroître la coopération bilatérale et régionale avec le Mexique et les autres pays par où transitent la cocaïne et l'héroïne afin de réduire l'entrée de drogues illicites aux États-Unis.

Objectif 4 : Soutenir et valoriser la recherche et la technologie – notamment la production de connaissances et de données scientifiques – afin de repérer et de saisir les drogues illicites qui transitent vers les États-Unis et aux frontières du pays et de démanteler et de décourager leur trafic.

But 5 : Démanteler les sources étrangères et nationales d'approvisionnement en drogues.

Objectif 1 : Réduire considérablement la culture mondiale de coca, d'opium et de marijuana et la production d'autres drogues illicites, en particulier la méthamphétamine.

Objectif 2 : Désorganiser et démanteler les grandes organisations internationales de trafic de stupéfiants et arrêter, poursuivre et incarcérer leurs chefs.

Objectif 3 : Participer aux efforts de lutte contre la drogue dans les pays producteurs et renforcer la volonté politique et les moyens de contrôle de ces pays en ce qui a trait aux drogues.

Objectif 4 : Mettre sur pied et soutenir des initiatives bilatérales, régionales et multilatérales et mobiliser les efforts des organisations internationales en vue de lutter contre tous les aspects de la production, du trafic et de la consommation de drogues illicites.

Objectif 5 : Promouvoir des politiques et des lois internationales visant à décourager le blanchiment d'argent et à faciliter les enquêtes sur le blanchiment d'argent ainsi que la saisie des revenus générés par cette activité.

Objectif 6 : Soutenir et valoriser la recherche et la technologie, notamment la production de données scientifiques, visant à réduire l'approvisionnement mondial en drogues illicites.

Administration de la politique

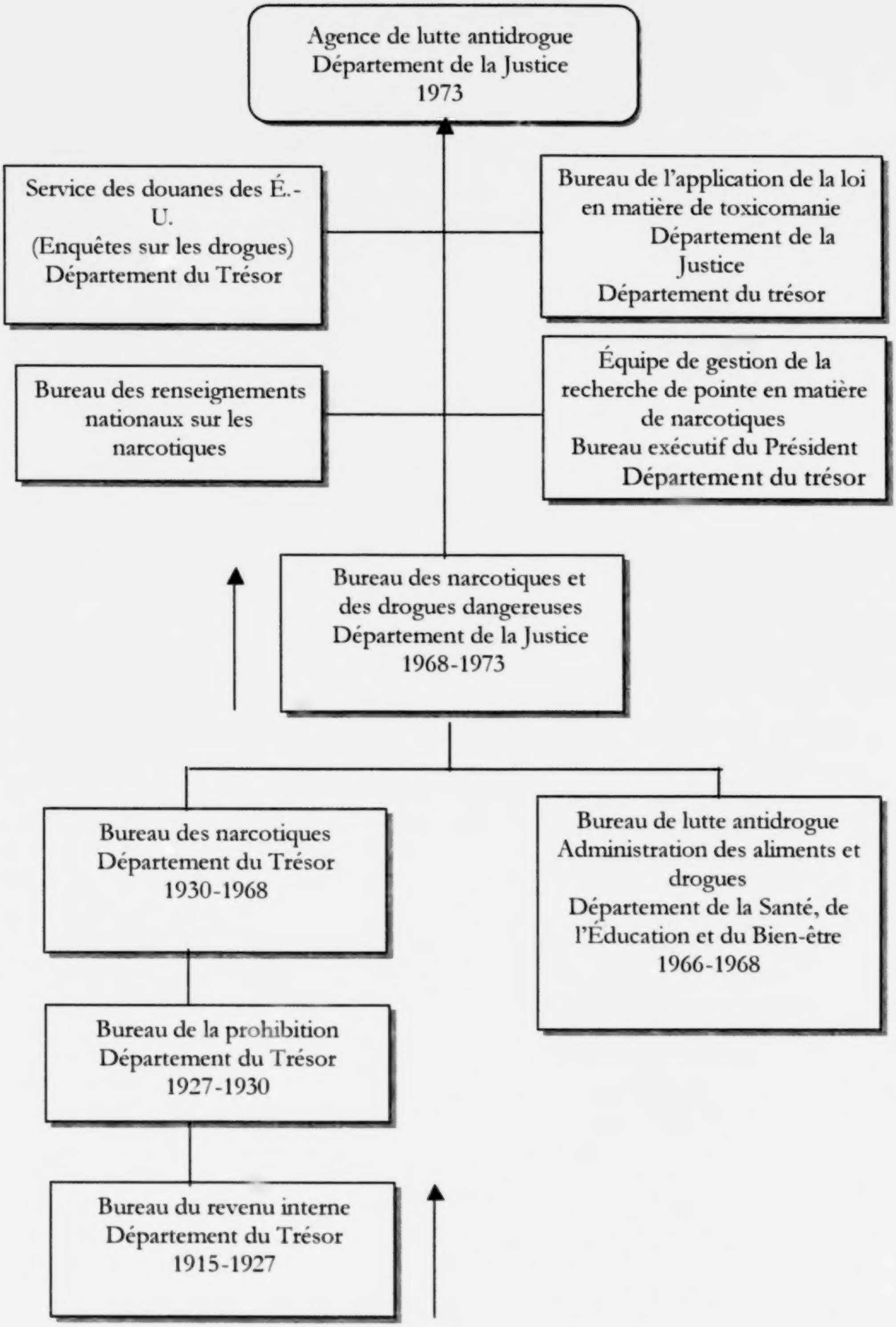
Comme nous l'avons dit plus haut, le budget national consacré à la lutte antidrogue est colossal. Plus de 18 milliards $ US sont prévus au budget de l'exercice 2001 pour soutenir les buts et les objectifs de la stratégie nationale de lutte contre les stupéfiants. De nombreux départements fédéraux, notamment ceux de la Défense, de l'Éducation et de la Justice, ainsi que le Département d'État et le Trésor, y participent et ils doivent souvent coordonner leurs efforts avec les gouvernements des États et les agences gouvernementales locales ainsi qu'avec une diversité de groupes communautaires et professionnels. Le Bureau de la politique nationale de lutte contre les stupéfiants assure la coordination de toutes ces activités.

Le département de la Justice, l'un des acteurs clés, est responsable des nombreuses agences œuvrant dans ce domaine et il reçoit une part importante du budget consacré à la lutte contre les stupéfiants, soit plus de 8 milliards $ US en 2001[234] Il finance diverses agences, notamment le *Bureau of Prisons*, le *F.B.I.*, INTERPOL, le *U.S. Marshals Service*, *l'Immigration and Naturalization Service* et la *Drug Enforcement Administration* (DEA). La DEA[235] mérite une mention spéciale dans l'administration de la politique antidrogue par le département de la Justice. Sa mission consiste à appliquer les lois et les règlements sur les substances contrôlées et à recommander et appuyer des programmes visant à réduire la disponibilité des substances contrôlées illicites sur les marchés nationaux et internationaux. Créée en 1973, cette agence a succédé au FBN d'Anslinger et à d'autres organismes fédéraux d'application des lois, comme on peut le constater dans l'organigramme suivant.[236]

234 Source : Bureau exécutif du Président des États-Unis, *Summary: FY 2002 National Drug Control Budget*, avril 2001, page 11.

235 Adresse du site Web de la DEA : http://www.usdoj.gov/dea/.

236 Source : Site Web de la DEA :, http://www.usdoj.gov/dea/agency/genealogy.htm


Agence de lutte antidrogue
Département de la Justice
1973
Service des douanes des É.-U.
(Enquêtes sur les drogues)
Département du Trésor
Bureau de l'application de la loi en matière de toxicomanie
Département de la Justice
Département du trésor
Bureau des renseignements nationaux sur les narcotiques
Équipe de gestion de la recherche de pointe en matière de narcotiques
Bureau exécutif du Président
Département du trésor
Bureau des narcotiques et des drogues dangereuses
Département de la Justice
1968-1973
Bureau des narcotiques
Département du Trésor
1930-1968
Bureau de lutte antidrogue
Administration des aliments et drogues
Département de la Santé, de l'Éducation et du Bien-être
1966-1968
Bureau de la prohibition
Département du Trésor
1927-1930
Bureau du revenu interne
Département du Trésor
1915-1927

Outre ses fonctions d'application de la loi, la *DEA* gère le service national de renseignements sur les stupéfiants et elle est responsable, sous la direction stratégique du Secrétariat d'État et des ambassadeurs américains, de tous les programmes qui comportent un lien avec ses homologues chargés de l'application des lois sur les drogues dans les pays étrangers. À ce titre, l'Agence assure un lien avec les Nations Unies, l'Interpol et d'autres organisations sur les dossiers concernant les programmes internationaux de lutte contre les stupéfiants. Au nombre des mesures extra-territoriales prises par les Américains figurent « l'Opération Colombie », un programme visant à réduire la production de cocaïne dans ce pays et auquel plus d'un milliard de dollars ont été affectés, ainsi que des mesures conjointes d'application des lois prises de concert avec des gouvernements étrangers, notamment celui du Mexique. En outre, le *Foreign Assistance Act* oblige l'administration américaine à limiter considérablement l'aide bilatérale accordée aux pays considérés par la Maison Blanche comme de grands producteurs de stupéfiants ou comme principales routes d'acheminement des stupéfiants. De même, le *Foreign Narcotics Kingpin Designation Act* permet au président de désigner des étrangers comme « barons de la drogue » et, ainsi, de les priver de tout accès au système financier américain et de rendre illégale toute transaction entre eux et des entreprises ou des particuliers des États-Unis.

Sujets d'actualité et débats

Les coûts de l'incarcération, l'application plus fréquente des lois antidrogues aux minorités ethniques et la corruption policière qu'occasionne la guerre aux drogues font l'objet, dans ce débat permanent, d'une attention croissante. En effet, le gouverneur républicain du Nouveau Mexique a appelé à la décriminalisation de toutes les drogues – « Il faut en contrôler, en réglementer et en taxer la vente »[237] – signalant que préférer régler les problèmes découlant de l'abus des drogues en incarcérant les toxicomanes plutôt qu'en les traitant coûte de plus en plus cher. Lors de nos audiences, le Gouverneur nous a dit :

> *« (…) je pense que la guerre à la drogue a abouti à un échec retentissant. (…) Quand je constate que la moitié de l'argent que nous dépensons pour faire exécuter les lois, la moitié de l'argent que nous dépensons pour faire marcher les tribunaux et la moitié de l'argent que nous dépensons pour faire fonctionner les prisons est lié à la drogue, je sais que c'est là le problème le plus important auquel nous sommes confrontés aujourd'hui. Aux États-Unis, nous dépensons chaque année 50 milliards $ à cause d'activités criminelles reliées à la drogue. (…) Aux États-Unis, les deux-tiers des détenus sont incarcérés à la suite de condamnations ayant trait à la drogue. Près de 500 000 personnes, un quat de la population carcérale, sont en prison à cause d'actes liés aux drogues. Il en coûte aux États-Unis plus de 8,6 milliards $ par an juste pour garder enfermés des gens condamnés pour une infraction liée aux*

[237] « New Mexico Governor Calls for Legalizing Drugs », CNN.com, 6 octobre 1999. Disponible en ligne à : www5.cnn.com/US/9910/06/legalizing.drugs.01/.

> *drogues. En dépit de toutes ces dépenses, les drogues illicites sont maintenant moins chères, plus disponibles et plus fortes qu'elles ne l'étaient il y a 20 ans.*
> *(...) Aux États-Unis, quand les gens sont arrêtés, c'est parce qu'ils possèdent laquelle de ces substances? Nous arrêtons 1,6 million de personnes par an. La population du Nouveau Mexique est de 1,8 million d'habitants. J'habite le Nouveau-Mexique, un état gigantesque, et quand je m'y promène, je ne peux pas m'empêcher de penser que l'équivalent de la population de Nouveau-Mexique est arrêtée chaque année aux États-Unis. C'est absolument choquant. Sur ces 1,6 million d'arrestations, il y en a 800 000 pour possession de marijuana et la moitié du temps ce sont des Hispaniques qui sont arrêtés. Est-ce que la moitié des consommateurs de marijuana des États-Unis sont des Hispaniques? Non, pourtant on arrête de façon disproportionnée parmi la communauté hispanique.*
> *Dans l'état actuel des choses que devons-nous faire? Premièrement il faut légaliser la marijuana. Deuxièmement, il faut adopter des stratégies de réduction des méfaits en ce qui concerne toutes les autres drogues. Troisièmement, il faut passer d'une approche axée sur la criminalisation à un modèle médical. »*[238]

D'autres dénoncent la politique actuelle parce que les Afro-américains sont ciblés de façon disproportionnée par les agents d'application des lois antidrogue. Le groupe *Human Rights Watch* a révélé, dans une étude publiée en 2000, que les Noirs comptent pour 62,7 % de l'ensemble des contrevenants incarcérés dans les prisons d'État pour des infractions liées aux drogues, tandis que les Blancs n'en représentent que 36,7 %, même si les données confirment que ce clivage racial « n'a qu'un lointain rapport avec l'écart numérique séparant les Noirs et les Blancs qui contreviennent aux lois antidrogue »[239]. Divers experts signalent aussi l'effet délétère des drogues sur l'application des lois, notamment Joseph McNamara, ancien chef de police de San Jose, Californie, maintenant à la retraite, selon lequel la corruption des fonctionnaires sera un problème grave « tant que la politique antidrogues actuelle restera en vigueur »[240].

---

[238] Témoignage du Gouverneur Gary E. Johnson, Nouveau-Mexique, devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 5 novembre 2001, fascicule 9, pages 36 à 38.

[239] Fellner, Jamie, avocat-conseil pour Human Rights Watch, « United States: Punishment and Prejudice: Racial Disparities in the War on Drugs », Human Rights Watch, mai 2000, au paragraphe 2 de « Summary and Recommendations ». Disponible en ligne à : www.hrw.org/reports/2000/usa.

[240] McNamara, J. D., « When Cops Become the Gangsters », Los Angeles Times, 21 septembre 1999. Disponible en ligne à : www.nakedgov.com/mcnamara.htm.

Statistiques

Nous avons présenté au chapitre 6 un ensemble de données sur l'usage de cannabis. Nous terminons cette description de la situation aux USA par un ensemble de tableaux sur certains indicateurs sélectionnés.

Estimation de la consommation nationale de drogues aux États-Unis (en tonnes métriques)[241]

Année	Cocaïne	Héroïne	Marijuana	Méthamphétamine
1996	288	12,4	874	14,3
1997	312	13,1	960	11,9
1998	291	12,5	952	15,9
1999	276	12,9	982	15,5
2000	269	12,9	1 009	15,5

Enquête nationale de 1997 auprès des ménages sur l'abus de drogues : consommation de drogues illicites dans le passé[242]

Âge du répondant	Jamais consommé	L'année dernière	Le mois dernier
12 – 17	23,7 %	18,8 %	11,4 %
18 – 25	45,4 %	25,3 %	14,7 %
26 – 34	50,8 %	14,3 %	7,4 %
35 et plus	31,5 %	6,1 %	3,6 %

Quantité de drogue consommée en 1998 par des élèves du secondaire supérieur[243]

Drogue	Jamais consommé	L'an dernier	Le mois dernier
Marijuana	49,1 %	37,5 %	22,8 %
Cocaïne	9,3 %	5,7 %	2,4 %
Crack	4,4 %	2,5 %	1 %
Stimulants	16,4 %	10,1 %	4,6 %
LSD	12,6 %	7,6 %	3,2 %
PCP	3,9 %	2,1 %	1 %
Héroïne	2 %	1 %	0,5 %

241 Source : Bureau de la politique nationale de lutte contre les stupéfiants. 2000. *What America's Users Spend on Illegal Drugs, 1988-1998.*

242 Source : Bureau de la politique nationale de lutte contre les stupéfiants, Centre de documentation sur la politique antidrogue, *Drug Data Summary*, avril 1999.

243 *Ibid.*

Prix des drogues et degrés de pureté : années choisies entre 1981 et 1998[244]

Quantité achetée	1981 Prix/Pureté (le g pur)	1988 Prix/Pureté **(le g pur)**	1996 Prix/Pureté (le g pur)	1997 Prix/Pureté (le g pur)	1998 Prix/Pureté (le g pur)
Cocaïne					
1 g ou moins	378,70$/ 40,02 %	218,33$/ 75,99 %	159,05$ 72,5 %	178,97$/6 4,72 %	169,25$/7 1,23 %
10 à 100 g	191,5/ 59,59 %	78,84/ 83,53 %	49,45/ 68,44 %	45,58/67, 05	44,30/65, 92
Héroïne					
0,1 g ou moins	3 114,80/4, 69	2 874,19/1 9,22	2 175,88/ 23,95	2 114,97/2 5,24	1 798,80/2 4,29
1 à 10 g	1 194,05/1 9,1	947,32/39, 48	373,30/45 ,21	327,88/45, 38	317,97/51, 33
Marijuana					
10 g ou moins	6,41 $	12,50 $	10,42 $	10 $	10,41 $
100 à 999 g	2,75	3,41	2,95	2,63	2,59

Budget national consacré à la lutte contre les drogues[245]

Année	Montant (en milliards de $US)
1999	17,1
2000	17,9
2001	18,1
2002	19,2

---

244 *Ibid.*

245 Ces chiffres représentent les fonds dépensés pour soutenir les buts et les objectifs de la Stratégie nationale de lutte contre les stupéfiants et comprennent les sommes figurant au budget de divers départements, notamment Défense, Éducation, Justice, État et Trésor. Source : *National Drug Control Budget Executive Summary, Fiscal Year 2002*, Bureau de la politique nationale de lutte contre les stupéfiants, 9 avril 2001.

Estimation du nombre total d'arrestations et du nombre d'arrestations liées aux drogues

1989-1999[246]

Année	Nombre total d'arrestation	Arrestations toutes drogues confondues		Répartition des arrestations pour infractions liées aux drogues					
				Héroïne/Cocaïne		Marijuana		Autres	
		Nombre	%	Vente	Possession	Vente	Possession	Vente	Possession
1989	14 340 900	1 351 700	,4	19,1	34,7	6,2	23,1	7,0	9,8
1990	14 195 100	1 089 500	,6	21,0	33,3	6,1	23,9	4,5	11,2
1991	14 211 900	1 010 000	,1	22,5	32,8	6,1	22,4	4,8	11,5
1992	14 075 100	1 066 400	,5	20,6	32,4	6,6	25,5	4,6	10,4
1993	14 036 300	1 126 300	,0	19,2	31,1	6,2	27,6	4,3	11,6
1994	14 648 700	1 351 400	,2	16,8	30,3	5,8	29,8	4,1	13,2
1995	15 119 800	1 476 100	,7	14,7	27,8	5,8	34,1	4,4	13,3
1996	15 168 100	1 506 200	,9	14,2	25,6	6,3	36,6	4,3	13,3
1997	15 284 300	1 583 600	0,3	10,3	25,4	5,6	38,3	4,7	15,8
1998	14 528 300	1 559 100	0,7	11	25,6	5,4	38,4	4,8	14,8
1999	14 031 070	1 532 200	0,9	10	24,5	5,5	40,5	4,1	15,4

[246] Source : *Crime in the United States: Uniform Crime Reports*, U.S. Department of Justice, Federal Bureau of Investigation (1990-2000).

Adultes emprisonnés dans des établissements carcéraux des États ou du gouvernement fédéral ou dans des prisons locales, 1989-1999[247]

Année	Prisons d'État	Prisons fédérales	Total – prisons d'État & fédérales	% de personnes incarcérées pour infractions liées à la drogue		Prisons locales
				Fédérales	État	
1989	629 995	53 387	683 382	49,9	19,1	395 553
1990	684 544	58 838	743 382	53,5	21,7	405 320
1991	728 605	63 930	792 545	55,9	21,3	426 479
1992	778 495	72 071	850 566	58,9	22,1	444 584
1993	828 566	80 815	909 381	59,2	22,1	459 804
1994	904 647	85 500	990 147	60,5	22,4	486 474
1995	989 004	89 538	1 078 542	59,[illegible]	22,7	507 044
1996	1 032 440	95 088	1 127 528	60,0	22,7	518 492
1997	1 059 588	99 175	1 176 922	62,6	20,7	567 079
1998	1 178 978	123 041	1 232 900	58,7	20,7	592 462
1999	1 209 123	135 246	1 366 369	57,8	Données non disponibles	605 943

Populations correctionnelles aux États-Unis : statistiques choisies pour 1997[248]

En 1997, environ 5,7 millions de résidents adultes américains (soit près de 2,8 % de l'ensemble de la population adulte résidant aux États-Unis) se trouvaient sous une forme ou une autre de surveillance correctionnelle. Environ 70 % étaient sous surveillance dans la collectivité, en probation ou en libération conditionnelle. Près de 9 % des adultes Noirs étaient sous supervision correctionnelle tandis que chez les adultes Blancs, ce chiffre s'établissait à 2 % et pour les autres races, le total s'établissait à 1,3 %.

Poursuites fédérales pour des infractions liées aux drogues : statistiques choisies pour 1999[249]

En 1999, les procureurs américains ont entamé des procédures d'instruction touchant 117 994 suspects. Dans 32 % des cas, il s'agissait de poursuites pour des infractions liées à la drogue. Le nombre de suspects comparaissant devant un tribunal

---

[247] Sources : Bureau of Justice Statistics Bulletin, *Prisoners in 1999* (Aug, 2000), *Prisoners in 1998* (Aug, 1999), *Prisoners in 1997* (Aug, 1998), *Correctional Populations in the United States*, 1995, 1994, 1993, 1992, 1991, 1990, 1989. *Jails and Jail Inmates*, 1993-94. *Jail Inmates*, 1992; 1990. Les données relatives aux pourcentages pour 1997 de personnes condamnées pour des infractions liées à la drogue sont tirées du rapport spécial sur les statistiques du bureau de la Justice, *Substance Abuse and Treatment, State and Federal Prisoners, 1997* (janvier 1999) et de données non publiées provenant du Bureau des prisons.

[248] Source : *Correctional Populations in the United States, 1997*, Bureau des statistiques de Justice, Département de la Justice des É.-U., (novembre 2000).

[249] Source: U.S. Compendium of Federal Judicial Statistics, 1999, (avril 2001).

de district des États-Unis pour des infractions liées à la drogue (77 %) était supérieur à celui des suspects poursuivis pour des crimes violents (59 %), des infractions contre l'ordre public (53 %) ou des infractions contre la propriété (50 %). Parmi les contrevenants reconnus coupables de crimes graves (« *felony* ») liés à la drogue par un tribunal fédéral en 1999, 93 % ont été condamnés à des peines d'emprisonnement. La durée moyenne des peines pour tous les contrevenants condamnés par un tribunal fédéral en 1999 était de 57,8 mois; pour les infractions liées à la drogue, la durée moyenne était de 75,4 mois.

Saisies de biens autres que des drogues effectuées par la DEA – 1997[250]

Au cours de l'exercice 1997, la *Drug Enforcement Administration* a procédé à 15 860 saisies de biens autres que des drogues en vertu des lois sur la confiscation de drogues. La valeur totale de ces biens est estimée à 552 millions $ US.

Type de biens	Nombre de saisies	Valeur (en dollars)
Devises	8 123	284 680 029
Autres instruments financiers	507	73 602 092
Biens immobiliers	748	108 833 498
Véhicules	3 695	47 379 874
Embarcations	111	5 884 754
Aéronefs	24	8 945 000
Autres moyens de transport	172	1 734 731
Autres	2 480	1 734 731

250 Source : Centre de documentation du Bureau de la politique nationale de lutte contre les drogues, *Drug Data Summary*, Avril 1999.

CHAPITRE 21

OPTIONS DE POLITIQUE PUBLIQUE

Une politique publique ne se réduit pas à la législation habilitante, dans ce cas-ci la loi pénale. Pourtant, en matière de drogues illicites, la législation pénale occupe une place symbolique et matérielle déterminante. En fait, tout se passe comme si elle était l'ossature même de toute la politique publique. Les débats publics sur le cannabis ne tournent pas autour des questions de santé publique, de santé des usagers, ou de prévention des usages à risque et excessifs, mais portent sur les questions de savoir s'il faut décriminaliser ou non, créer une infraction civile ou garder une infraction pénale, si l'on peut légaliser et jusqu'où. D'ailleurs, au moment même où nous mettons la dernière main à notre rapport, le ministre de la Justice du Canada lance précisément quelques ballons d'essai sur la « décriminalisation » du cannabis. Indépendamment des mérites de cette approche – que la suite de ce chapitre explicitera et commentera – il est clair pour nous que modifier ici ou là la loi pénale ne fait pas une politique publique en la matière. En ce qui nous concerne, **une politique publique en matière de cannabis doit être d'abord et avant tout, et essentiellement, une politique de santé publique axée sur la responsabilisation des pouvoirs publics et des usagers**.

Sur un plan général, la tendance à réduire les débats sur les drogues à leur support juridique s'inscrit sûrement dans le contexte de la juridicisation croissante des relations sociales, où l'adoption d'une loi est devenue l'outil central, parfois unique, de la politique d'État. Mais en matière de drogues illicites, il y a d'autres facteurs à l'oeuvre.

D'une part, cette attitude s'inscrit au cœur même des approches adoptées depuis le début du XXe siècle en matière de drogues, où la prohibition pénale a été le fil conducteur – et réducteur – des politiques publiques. Ce n'est en fait qu'en raison de la « crise » du sida que l'on a « découvert » les mérites d'une approche de réduction des méfaits pour les usagers de drogues. Découverte qui n'était pas nécessairement fondée, chez les décideurs, sur une volonté de protéger la santé des usagers de drogues autant que sur la protection de la société des non-usagers. De même quand on s'est attaqué aux problèmes de criminalité découlant de la criminalisation des drogues pour les usagers (nous ne parlons pas ici de la criminalité organisée des narcotrafiquants) ce n'était pas tant pour améliorer leurs conditions de vie que pour protéger les non-usagers des « méfaits » de l'usage de drogues.

D'autre part, l'interdit pénal demeure souvent, dans les mentalités, le «dernier rempart » contre la prolifération incontrôlée de l'usage de drogues. Sans l'interdit pénal, nous a-t-on dit, la consommation de cannabis pourrait bien exploser et être hors contrôle. L'hypothèse sous-jacente, rarement rendue explicite, voulant que la criminalisation des drogues contribue effectivement à en diminuer l'usage, n'a pourtant jamais été démontrée. Et ce chapitre démontrera que tout donne à penser que les politiques héritées de la prohibition ont peu d'effet sur les niveaux d'usage aussi bien que sur la disponibilité des drogues.

Une politique publique se réduit d'autant moins à l'adoption d'une législation que les lois ne contiennent que trop rarement des énoncés de principes directeurs qui permettraient d'en connaître les buts et objectifs. En matière de drogues illicites, où les enjeux relèvent de la santé publique et de la culture (incluant l'éducation et la recherche) d'abord et avant tout, et où le droit pénal ne devrait constituer qu'un dernier recours, une politique publique doit reposer sur des principes intelligibles et énoncer des objectifs clairs. Et pour se matérialiser, elle doit disposer de l'ensemble des outils capables d'agir sur les divers enjeux que les drogues posent aux sociétés. La législation est l'un de ces outils.

Les coûts sociaux et économiques des drogues illicites touchent de vastes pans de l'organisation sociale : ils se comptent en baisse de productivité et en pertes pour les entreprises, en heures d'hospitalisation et soins médicaux de toutes sortes, en temps policier et en jours d'incarcération, et en vies brisées ou perdues. Même si personne ne peut dire exactement quelle en est la proportion, une partie de ces coûts provient non pas des substances elles-mêmes mais du fait qu'elles soient criminalisées. La drogue qui est le plus souvent associée à la violence et à des infractions criminelles, incluant la conduite avec facultés affaiblies, est en fait la seule qui soit légale : l'alcool.[1] Quant au cannabis, hormis les réseaux criminalisés qui contrôlent une part du circuit de production et de distribution, il n'entraîne pas de criminalité ni d'insécurité. Même ses coûts sociaux et de santé sont relativement limités par rapport à ceux de l'alcool et du tabac. En fait, plus que pour n'importe quelle autre drogue illicite, nous pouvons affirmer que **c'est sa criminalisation qui est la principale source de coûts sociaux et économiques**.

Pourtant, malgré que les principaux coûts sociaux des drogues touchent les entreprises, la santé ou les familles, la trop grande importance du discours juridique crée un déséquilibre de l'action publique au profit des agences chargées de l'application de la loi. Personne ne niera que leur travail soit nécessaire pour assurer l'ordre et la paix publique et pour lutter contre la criminalité organisée. Au même moment, le fait que 90 % et plus des ressources soient consacrées à l'application de la loi, que les actions les plus visibles dans la sphère publique sur les drogues soient les opérations policières et les décisions des tribunaux, et que, au moins en matière de cannabis, la loi soit en

---

[1] Là-dessus, nous renvoyons à la récente étude menée pour le CCLAT : Permanen, K. et. al. (2002) *op. cit.*

décalage par rapport aux attitudes et opinions des citoyens, crée un fossé réel entre les besoins et la pratique.

La plupart des stratégies nationales connaissent une forme semblable de déséquilibre. Mais les stratégies nationales qui semblent les mieux à même de réussir sont celles qui se donnent des moyens pour corriger ce déséquilibre. Ces stratégies mettent en place des outils de connaissance et d'observation, identifient des indicateurs de réussite par rapport à leurs objectifs, et créent un véritable centre nerveux de mise en œuvre et de suivi de la politique publique. La loi, la loi pénale notamment, est alors remise à sa place qui est celle d'un moyen parmi d'autres pour atteindre les objectifs fixés et non de devenir un but en soi.

Ce chapitre se divise en trois sections. La première porte précisément sur la question de l'efficacité des mesures légales de lutte aux drogues et démontrera que les régimes juridiques ont peu d'effets sur la consommation ou sur l'offre. La seconde section décrit les diverses composantes d'une politique publique. Et la troisième réfléchit sur les orientations de la politique pénale, définissant au passage les principaux termes qui sont utilisés : décriminalisation, dépénalisation, déjudiciarisation, légalisation, réglementation.

L'INEFFICACITÉ DES POLITIQUES PÉNALES

On utilise généralement deux indicateurs clés pour mesurer l'efficacité des politiques pénales en matière de drogues : la diminution de la demande et la diminution de l'offre. Certains auteurs tentent aussi de mesurer l'efficience économique de diverses options de contrôle[2] mais nous laisserons cet aspect de côté, les données demeurant trop incomplètes.

Les moyens de mesurer l'impact des politiques publiques sur l'offre et la demande se heurtent à une série d'embûches méthodologiques. Premièrement, ces deux indicateurs sont relativement artificiels et surtout ne sont pas séparés l'un de l'autre ; c'est-à-dire que les actions sur l'un et sur l'autre sont concurrentes, souvent le fait des mêmes acteurs – pensons par exemple aux policiers qui font de «l'éducation» aux drogues dans les écoles, agissant théoriquement sur la demande mais faisant sûrement en même temps un travail susceptible de mener à une réduction de l'offre. Deuxièmement, la capacité des institutions responsables d'agir sur l'un et l'autre dépend en retour de toute une série d'indicateurs relatifs à leurs moyens et ressources, leurs pratiques et habiletés, leur compétence. Ainsi, pour la police, le nombre de policiers par habitant et les orientations générales des forces de l'ordre (police communautaire, police traditionnelle plus réactive) de même que la priorité accordée aux infractions reliées aux drogues, peuvent influencer le nombre d'incidents signalés et les décisions

---

[2] Sur cette question voir Jackson, A.Y. (2002) *op. cit.*, et la discussion au chapitre 18.

de porter des accusations. Plus généralement, la quantité globale des ressources consacrées par un État à sa politique sur les drogues pourrait avoir un effet sur l'un et l'autre de ces indicateurs. En somme, la mesure de l'efficacité n'est pas immédiate.

Il est encore plus difficile d'évaluer, même indirectement, les effets des actions mises en œuvre, quand des objectifs clairs, idéalement accompagnés d'indicateurs, ne sont pas définis par l'autorité publique, ce qui est le cas au Canada actuellement comme nous l'avons vu au chapitre 11. Ceci étant, à défaut d'être en mesure de proposer une évaluation rigoureuse des politiques publiques sur les drogues, nous examinerons la question par le biais d'une série d'indicateurs indirects.

Des impacts sur la consommation ?

Orientation générale des politiques

Au niveau le plus général, les États, comme nous l'avons vu au chapitre précédent, donnent une orientation générale à leurs politiques sur les drogues : certaines plus tolérantes ou permissives comme aux Pays-Bas (mais aussi en Belgique, Espagne ou Allemagne) d'autres plus axées sur la prohibition et la non consommation comme aux États-Unis, en Suède ou en France. Ce sont là des catégorisations crues, réductionnistes de la complexité des politiques des uns et des autres. Même aux USA, où se poursuit une politique de «guerre à la drogue », les actions menées couvrent un vaste champ. De plus, entre le discours de politique publique et sa traduction dans des actions concrètes, il y a souvent un écart important. Par exemple, le discours répressif en France s'accompagne d'une activité policière limitée à l'endroit des usagers. Au Canada, plusieurs témoins nous ont dit que l'activité répressive de la police n'est pas suivie d'effet par les décisions des tribunaux. Il n'y a donc pas adéquation directe entre les énoncés politiques et les actions menées concrètement.

Diverses études comparatives ont tenté de répondre à la question de savoir si les politiques publiques influent sur les niveaux de consommation. Une étude menée par Reuband compare des pays européens «tolérants » (Pays-Bas, Espagne, Danemark et Italie) à des pays restrictifs (Allemagne, France, Norvège, Royaume-Uni et Suède). Cette étude n'a pas observé de différences significatives entre les niveaux de consommation, quelles que soient les orientations des politiques publiques.[3]

Le message du Conseil fédéral suisse sur la révision de la loi sur les stupéfiants rapporte les résultats d'une étude comparative de Cesoni sur 7 pays européens qui concluait que le régime juridique n'avait pas d'influence sur la fréquence de consommation.[4]

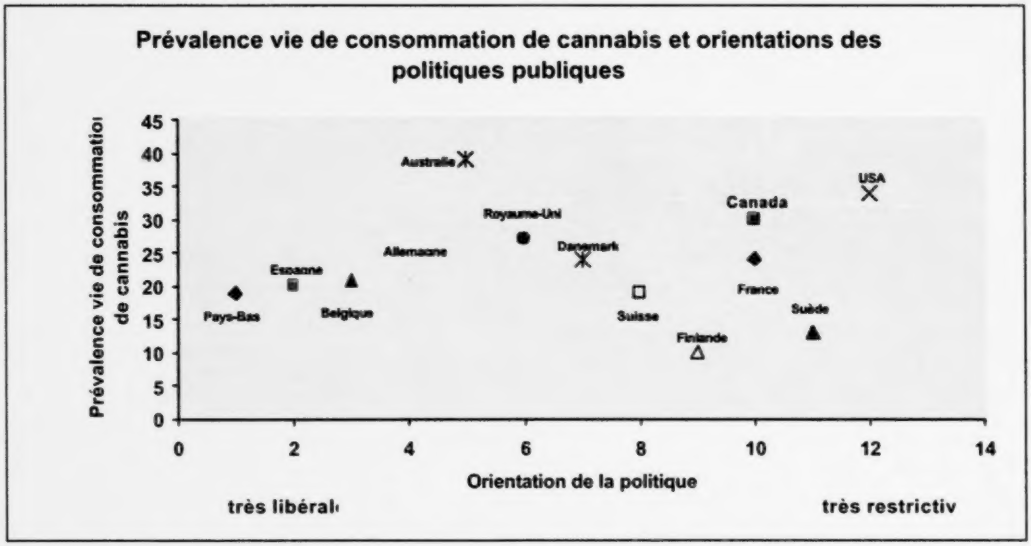
---

[3] Reuband, K., (1995) « Drug use and drug policy in Western Europe. » *European Addiction Research*, vol 1, pages 32-41.

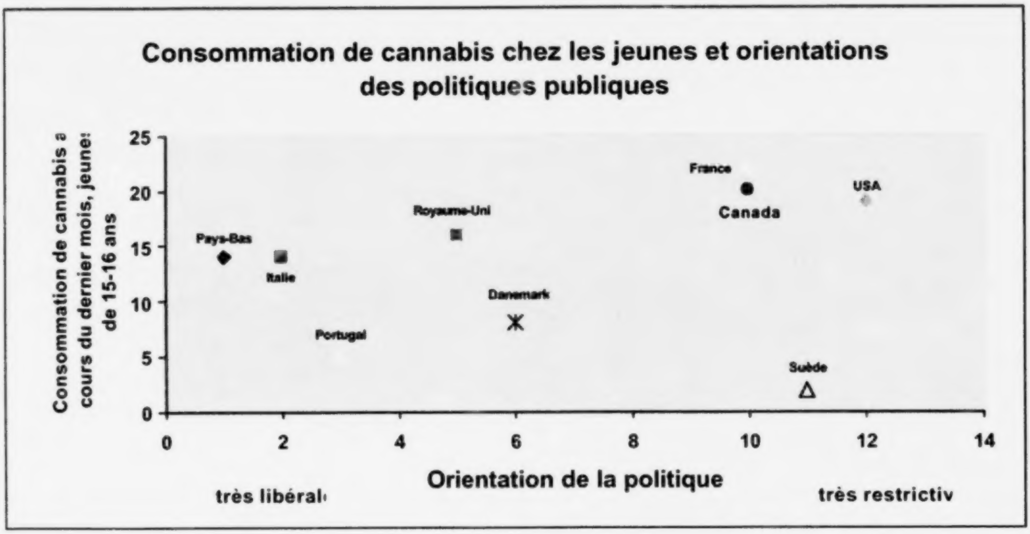
[4] Cesoni, L.L. (1999) « Usage et actes préparatoires de l'usage des drogues illicites : les choix en matière d'ncrimination. Analyse comparative de l'usage de drogues illicites de sept législations européennes. In Conseil fédéral suisse, *op. cit.*, page 3560.

Une autre étude réalisée pour l'Office fédéral suisse de la Santé publique classe les politiques de pays européens sur un axe allant de « très libérale » à « très restrictive » et les met en relation avec la prévalence vie de consommation de cannabis. L'étude n'a pas observé de relation entre la sévérité de la législation et le niveau d'usage.[5]

Nous avons produit deux graphiques similaires, classant de la même manière les politiques des pays en ajoutant le Canada, l'Australie et les États-Unis. Nous avons utilisé les données du chapitre 6 sur la prévalence vie de consommation dans la population générale (graphique 1) et au cours du dernier mois chez les 15-16 ans (graphique 2).



[5] Conseil fédéral Suisse (2001) *Message concernant la révision de la loi sur les stupéfiants*, page 3560.



Ces graphiques démontrent qu'il n'y a pas de relation immédiate entre les tendances de consommation et les orientations des politiques publiques. Des pays à tendance très libérale ont des taux faibles (Espagne, Pays-Bas ou Portugal), tandis que des pays avec des politiques très restrictives ont des taux élevés (USA, Canada, France). Évidemment cette absence d'association peut s'expliquer par le fait que ces données statistiques sont statiques – il ne s'agit pas de séries temporelles – et donc peu sensibles aux variations qui peuvent se produire d'une année à l'autre. Mais elle s'explique peut-être aussi par le fait qu'il se ferait peu d'arrestations d'usagers, traduisant ainsi une incohérence entre les discours et les actions concrètes. C'est ce qu'examine la section suivante.

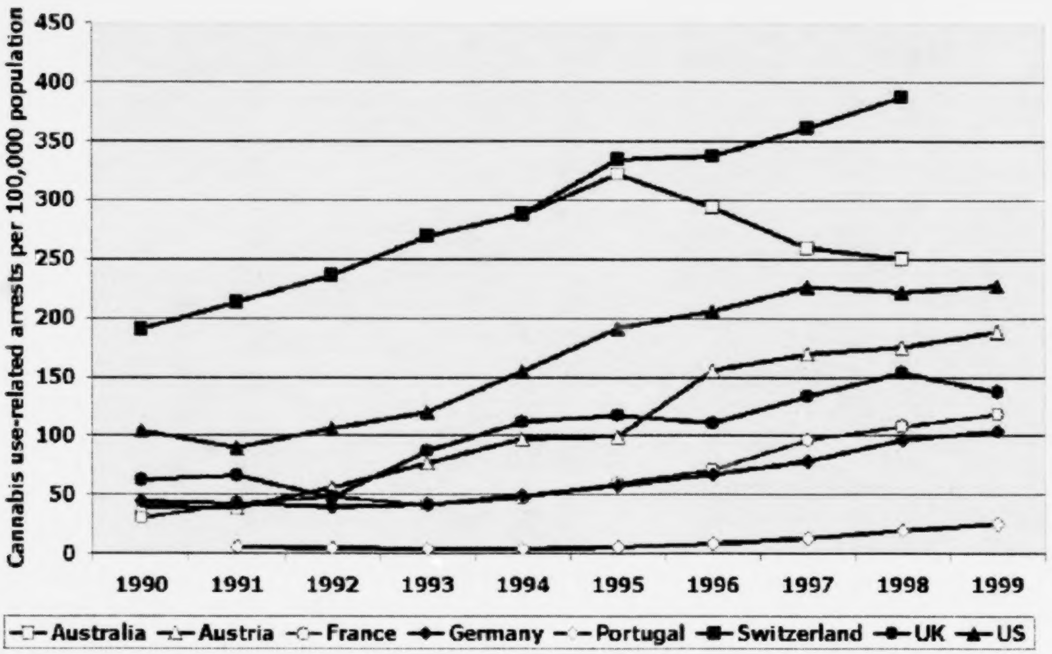
Consommation de cannabis et arrestations

Divers auteurs ont examiné la relation entre les niveaux d'arrestation et la délinquance généralement, la consommation de drogues en particulier. L'une des études récentes a été menée par Kilmer[6] dans le cadre de la Conférence scientifique européenne sur le cannabis. Nous reproduisons ce graphique à la page suivante.[7]

---

[6] Kilmer, B., (2002) «Do cannabis possession laws influence cannabis use ? » in Pelc, I. (dir.) *International Scientific Conference on Cannabis.* Bruxelles.

[7] Ne disposant pas de la base de données originales, nous reproduisons le graphique en langue anglaise originale ; les lecteurs francophones nous pardonneront cet écart.

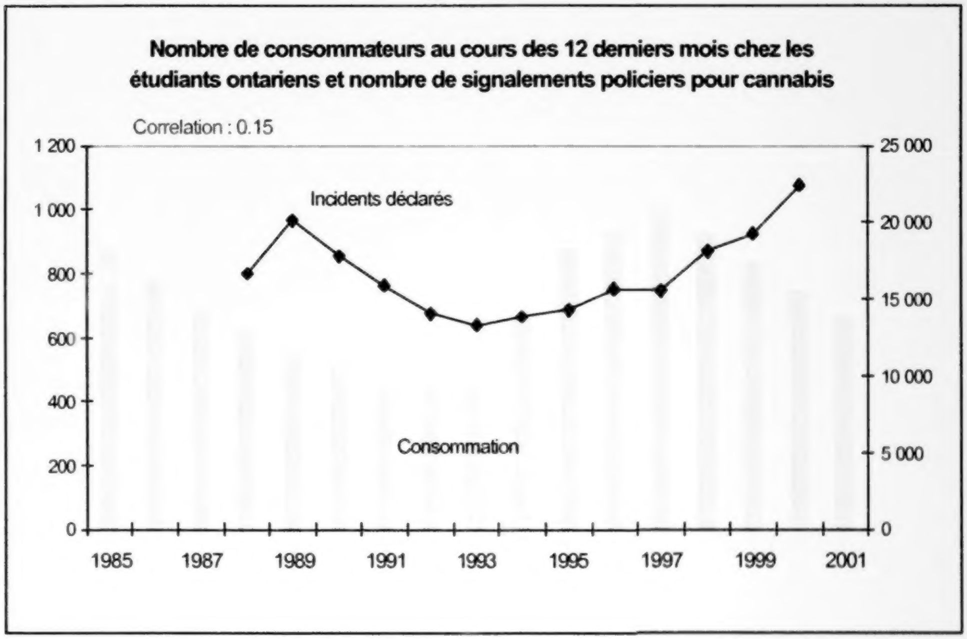


Ce graphique démontre que, dans tous les pays, le nombre d'arrestations par habitant pour possession simple de cannabis a augmenté au cours de la période 1990 – 1999, à l'exception de l'Australie. On observe que la Suisse, considérée comme relativement modérée actuellement, connaît le nombre le plus élevé d'arrestations par habitant, suivis par les USA, l'Autriche, le Royaume-Uni, la France et l'Allemagne.

Ici encore, il ne transparaît pas de relation immédiate entre les orientations de la politique publique et les décisions d'arrestation. Avec une orientation beaucoup moins sévère, la Suisse et l'Australie arrêtent proportionnellement plus que les USA, la Suisse ayant des taux de consommation nettement moins élevés que ceux des USA, tandis que ceux de l'Australie sont à peu près identiques.

Le nombre de policiers par habitant n'explique pas cette variation des taux d'arrestation : la France a beaucoup plus de policiers que les USA ou le Royaume-Uni mais arrête beaucoup moins que les USA et moins que le RU pour possession simple.

Nous avons produit un graphique mettant en relation l'usage de cannabis au cours des 12 derniers mois chez les étudiants de niveau secondaire en Ontario et les arrestations faites par les policiers pour possession de cannabis la même année. Nous avons choisi l'Ontario puisque c'est la seule province disposant de séries temporelles continues sur les niveaux de consommation, et que le niveau de signalement en Ontario est très près de la moyenne canadienne comme l'a démontré le chapitre 14. Le graphique suivant donne les résultats.



Ce graphique démontre une relation statistique très faible (0,15) entre l'activité policière et l'usage de cannabis. Autrement dit, l'activité policière ne dissuade pas les jeunes étudiants de faire au moins une expérimentation au cannabis.

Par ailleurs, la criminologie enseigne que ce n'est pas tant la sévérité des sentences qui importe pour dissuader de commettre une infraction que la probabilité de l'arrestation. En matière de lois sur les drogues, cette probabilité est très faible, comme le démontre le tableau suivant.

Probabilités d'arrestation pour possession de cannabis [8]

	1995	1996	1997	1998	1999
Allemagne			2,7 %		
Australie	3,7 %			2,1 %	
Autriche	1,7 %		1,7 %		2,0 %
Canada	1,8 %				
États-Unis	2,8 %	3,0 %	3,1 %	3,2 %	3,2 %
France					2,0 %
Royaume-Uni		2,1 %			
Suède			2,4 %	2,9 %	

[8] Tableau tiré de Kilmer, B., *op. cit.*, page 108.

Dépenses publiques

Si aucun des facteurs précédents n'est apparemment relié aux niveaux de consommation, peut-être le niveau de dépenses publiques l'est-il ?

Il est hasardeux de tenter d'estimer l'ensemble des coûts des politiques publiques en matière de drogues. Même sur un poste apparemment aussi précis que celui de l'application de la loi, les estimations sont imprécises : comme nous l'avons vu au chapitre 14, les coûts de l'application de la loi par les forces policières varient entre 700 millions $ et 1 milliard $. Les dépenses publiques spécifiques à la consommation de drogues pour le traitement ou la prévention, même si l'on sait qu'il s'agit de postes budgétaires nettement inférieurs à l'application de la loi, n'en sont pas moins imprécises.[9] Lorsqu'on veut faire des comparaisons internationales, les choses sont encore plus compliquées : les services sont organisés différemment, les coûts ne sont pas comptabilisés de la même manière, les orientations de service et plus généralement les orientations de l'État ne sont pas les mêmes.

Ces réserves faites, nous tentons néanmoins l'exercice à partir de données provenant de diverses sources. Pour rendre l'exercice un peu plus comparable, nous limitons la comparaison aux seules dépenses relatives à l'application de la loi, qui de toutes façons représentent entre 70 % et 90 % des dépenses publiques en matière de drogues illicites. Le tableau suivant résume les données. (Notons que, pour le Canada, nous avons utilisé les données de l'étude réalisée pour le CCLAT, et non les estimations que nous avons produites au chapitre 14 ; selon nos données le coût par habitant de l'application de la loi (police, justice et prisons), pourrait être de 30 $ par habitant.)

Coûts de l'application de la loi dans divers pays

	Coûts de l'application de la loi	Coûts per capita
Allemagne, 1992 [10]	6,3 milliards DM	
Australie, 1992 [11]	450 millions AUS $	
Canada, 1992 [12]	300 millions $ US	10 $ US
Etats-Unis [13]	12,3 milliards $ US	40 $ US
France, 1998 [14]	500 millions $ US	8 $ US
Pays-Bas [15]	230 millions $ US	15 $ US

[9] Là dessus, voir notamment Kopp, P. et P. Fenoglio (2000) *Le coût social des drogues licites (alcool et tabac) et illicites en France.* Paris : OFDT.

[10] Source : Rehm, J., (2001) *The Costs of public policies to fight illegal drugs.* Mémoire présenté au Comité spécial du Sénat sur les drogues illicites, page 13.

[11] Source : Rehm, J., (2001) *The Costs of public policies to fight illegal drugs.* Mémoire présenté au Comité spécial du Sénat sur les drogues illicites, page 13.

[12] Single, E., et coll., *op. cit.*

On constate que des pays avec des niveaux de consommation moyens (Allemagne, Pays-Bas) ont des dépenses plus faibles que les USA qui ont un taux de consommation élevé, et surtout que les dépenses d'application de la loi de ces pays sont supérieures à celles de deux pays nettement plus restrictifs que sont la France et le Canada.

Bref, ici encore, les niveaux de consommation de cannabis échappent à une détermination des politiques publiques axées sur la réduction de la demande par la répression de l'usage.

Des impacts sur l'offre ?

Les politiques publiques ont-elles des impacts sur la disponibilité ou les prix des drogues ? Les données disponibles semblent indiquer que non.

Malgré un effort soutenu de contrôle national et international et de lutte contre les trafics, macro comme micro, locaux aussi bien qu'internationaux, la disponibilité des drogues, du cannabis en particulier, n'a pas diminué. En ce qui concerne les prix, soit ils ont diminué significativement comme dans le cas de l'héroïne ou de la cocaïne, soit ils sont restés relativement stables comme dans le cas du cannabis et de ses dérivés.[16] L'augmentation relative du prix de certaines cultures de cannabis serait au moins autant reliée à l'effort d'amélioration de la «qualité » (niveau de THC, cultures organiques, etc.) et à la réalisation d'une marge de bénéfices importante pour les producteurs et trafiquants, qu'à l'effort des agences d'application de la loi.

Conclusion

Le titre de cette section annonçait notre conclusion: **si les politiques publiques ont pour but de réduire la consommation et l'offre de drogues, spécifiquement de cannabis, tout indique qu'elles ont échoué. Nous reprenons à notre compte les conclusions auxquelles sont arrivées les études suisses notamment: les politiques publiques axées sur l'interdiction de la consommation n'ont pas, ou très peu, d'influence sur les niveaux d'usage**.

On peut penser que la situation serait pire si ce n'étaient des efforts actuellement consentis à lutter contre les drogues illicites. C'est possible. À l'inverse, on peut aussi penser que les efforts de lutte qui occupent le centre de la scène entraînent des effets

---

[13] Source : Kopp, P. et C. Palle (1999) « Économistes cherchent politique publique efficace. » in Faugeron, C., (ed.) *Les drogues en France.* Paris : Georg, page 261.

[14] Source : Kopp, P. et C. Palle (1999) « Économistes cherchent politique publique efficace. » in Faugeron, C., (ed.) *Les drogues en France.* Paris : Georg, page 261.

[15] Source : Kopp, P. et C. Palle (1999) « Économistes cherchent politique publique efficace. » in Faugeron, C., (ed.) *Les drogues en France.* Paris : Georg, page 261.

[16] Voir là dessus, aux États-Unis, l'une des études les plus complètes sur la question : Abt Associates (2001) *The price of illicit drugs : 1981 through the second quarter of 2000.* Washington, DC : Office of National Drug Control Policy.

pervers plus grands que les bénéfices qu'ils ne produisent, notamment le non-respect de lois qui ne sont pas en phase avec les attitudes et pratiques de la population.

L'une des raisons de cet échec tient à la place centrale, trop importante en fait, qu'occupe le droit pénal dans une vision d'interdiction de l'usage, une orientation plus ou moins explicite mais toujours omniprésente, toujours déterminante, de l'horizon d'une société sans drogues.

Est-ce dire qu'il ne faille rien faire ? Nous ne le pensons pas. Est-ce dire qu'il faille laisser les seules lois du marché modeler les usages comme si les drogues étaient une marchandise comme une autre, ainsi que le proposent certains chantres du libre marché[17] ? Certainement pas. Les substances psychoactives, qu'il s'agisse de cannabis ou d'alcool ou de médicaments, ne sont pas des produits comme d'autres. Même le cannabis, dont nous avons vu au chapitre 7 qu'il n'a pas les effets délétères que certains lui prêtent et qu'il est, en comparaison avec le tabac, une substance à certains égards moins nocive, même le cannabis donc doit faire l'objet d'une certaine forme de régulation et d'une intervention de la puissance publique.

La question que nous pose le constat de l'échec patent et coûteux, aux plans humain, social comme économique, des orientations de politique publique que le Canada a retenues jusqu'à présent, est celle précisément de savoir quelles doivent être les orientations et les composantes d'une politique publique en matière de cannabis. Et dans ce contexte, quels seront le rôle et les orientations de la législation. C'est l'objet des sections qui suivent.

ÉCONOMIE GÉNÉRALE D'UNE POLITIQUE PUBLIQUE SUR LE CANNABIS

Nous sommes conscients qu'il y a quelque chose d'artificiel à la distinction obligée par notre mandat entre le cannabis et ses dérivés et les autres substances psychoactives. Certes, il n'y a pas un, mais des usages de substances. C'est vrai pour le cannabis comme ce l'est pour l'alcool, les médicaments, la cocaïne ou l'ecstasy. Les usages se différencient selon la substance – on ne consomme pas du cannabis comme on consomme des médicaments ni même de l'alcool. Mais il y a aussi un fond commun aux usages de substances psychoactives hors contexte médical : elles sont en priorité conçues comme une source de plaisir, voire comme un moyen d'augmenter la conscience et les sens. Il se trouvera bien entendu d'autres formes d'usage, l'abus par exemple n'étant plus axé sur le plaisir convivial mais sur un mécanisme d'ordre physiologique et psychologique témoignant d'une perte de contrôle voire d'une détresse. Mais aussi loin que remonte l'histoire les humains ont consommé des substances psychoactives pour des raisons ayant trait à l'émancipation de soi.

---

[17] Par exemple, l'économiste Milton Friedman.

Les usages se différencient aussi pour une même substance. L'usage de cannabis, associé d'abord au soin de soi – usages à caractère médical – et aux rites à caractère religieux, est devenu, dans les sociétés occidentales du XXe siècle, une expression de la contre-culture et du mouvement hippie, avant de devenir une drogue de consommation conviviale. Les usages de cannabis sont la plupart du temps autorégulés, mais dans un certain nombre de cas, lorsqu'ils s'inscrivent sur un fond de conduites à risque, ils peuvent mener à des abus.

Une politique publique sur les substances psychoactives doit être **intégrée** si elle veut être en mesure de saisir les dimensions communes aux usages de substances – surtout lorsqu'on constate des polyconsommations – et en même temps elle doit être capable de proposer des **approches adaptées** selon les substances.

Intégrée, une politique publique sur les drogues relèvera d'un centre nerveux capable de rassembler les fils conducteurs entre les substances et les usages et de proposer un sens aux usages de drogues. Autrement, dit, une approche ressemblant davantage à celle que met en œuvre la Mission interministérielle en France plutôt que l'éclatement entre divers centres de responsabilité à la fois en compétition et en vase clos les uns par rapport aux autres, comme en témoigne l'expérience américaine ou canadienne où drogues illicites, tabac et alcool relèvent de bureaucraties différentes.

Adaptée, une politique sera capable de proposer des modes d'appréhension ainsi que des outils spécifiques aux diverses substances et aux divers usages. L'usage abusif de cigarettes est une cause de cancer du poumon, pas de mortalité pour cause de conduite avec facultés affaiblies. Mais certains médicaments sont aussi susceptibles de causer des accidents mortels. Le cannabis peut être relié à l'un et à l'autre : cancers à cause de la combustion, accidents de la route à cause des ses effets psychomoteurs. Il faut donc être en mesure de saisir la spécificité en même temps que les points communs.

Intégrée et adaptée, une politique publique doit viser la connaissance des relations entre les substances et les modes et contexte d'usage, de sorte à cerner au plus près les éléments déterminants du passage d'une consommation autorégulée qui n'est pas problématique, aux conduites à risque et aux usages excessifs susceptibles de générer des problèmes. Les problèmes sont de deux ordres : pour la santé des usagers, et pour la santé et la sécurité des autres. Ces deux ordres de problèmes appellent des mesures distinctes. Certaines seront d'ordre préventif : faire connaître aux usagers les risques, et surtout les informer des facteurs à tenir en compte pour repérer chez soi, par soi-même, les marqueurs d'une conduite à risque qui peut entraîner des problèmes. Ils sont peu nombreux à être en mesure de le faire, mais les consommateurs de tabac qui fument de trois à cinq cigarettes par jour et s'y tiennent, ne sont probablement pas plus à risque de cancer du poumon que les non-fumeurs. Apprendre donc à gérer la consommation, à reconnaître les dangers, et disposer aussi de moyens et d'outils pour le faire. D'autres mesures sont d'ordre dissuasif : l'alcool au volant en est un bon exemple. Enfin, certaines mesures sont curatives : quelle que soit la substance, de la simple aspirine à l'héroïne, certaines personnes, pour toutes sortes de raisons bien

antérieures à la consommation de la substance elle-même, ont des conduites de consommation abusive qui mène à des problèmes de santé. Il faut avoir les outils pour le traitement et la guérison.

En ce sens, et c'est le troisième critère, une politique sur les substances psychoactives sera d'abord et avant tout une **politique de santé publique** : prévenir, dissuader des abus et traiter, sont bel et bien les trois grands moments de l'intervention en santé publique. Non qu'il s'agisse de vouloir la santé pour les autres ; non que la collectivité peut décider de ce que chacun fait au nom d'un quelconque et prétendu bien public ; mais plutôt une politique de santé publique qui, comme en matière d'alcool, contribue à **réduire les risques reliés** aux diverses formes d'usages des diverses substances. Une politique de santé publique sur les substances psychoactives est donc une politique de réduction des risques.

Les politiques de réduction des méfaits ont été associées à des actions telles l'échange de seringues, la prescription de méthadone ou d'héroïne. Pour certains même, une politique de réduction des méfaits aurait le double effet pervers de privilégier le rôle du médecin et de pouvoir coexister avec une approche prohibitionniste dont elle ne fait alors qu'atténuer les effets pervers.[18] Il s'agirait alors « d'une doctrine de transition, contradictoire et ambiguë, dont l'ambiguïté permet toutes les adaptations. »[19] Pire, selon le psychiatre américain Thomas Szasz, il s'agirait d'une position «moralement répugnante » traduisant le paternalisme thérapeutique de l'État.[20]

Nous pensons que l'essentiel est de reconnaître (1) que les usages de substances psychoactives ne peuvent être éliminés, qu'ils font partie de l'expérience humaine et que tous les usages ne sont pas des abus – quelle que soit la substance – et en même temps (2) que toutes les substances peuvent entraîner des conséquences négatives pour l'usager comme pour la société et qu'il convient alors de contribuer au bien-être des individus et de la collectivité en informant, en offrant des outils de prévention des abus, et en assurant qu'existe une infrastructure de soins. Reconnaître, autrement dit, qu'on n'est pas moins citoyen, ni moins bon citoyen, parce qu'on consomme du cannabis plutôt que de l'alcool, ou parce qu'on fait le choix d'en prendre plutôt que d'être abstinent, mais qu'individus et sociétés auront, selon les circonstances et modes de consommation, des besoins distincts.

Enfin, une politique publique sur les drogues ne cible pas les usagers mais les intègre dans sa mise en œuvre. Trop longtemps, lorsqu'il est question de drogues illicites, incluant le cannabis, on a cherché à connaître les caractéristiques particulières des consommateurs. Comme s'ils avaient quelque chose de particulier qui les distinguerait fondamentalement des usagers de tabac, d'alcool, ou de médicaments psychotropes détournés de leur usage médical. Il se peut que les usagers à problème

---

[18] Par exemple, l'appréciation critique que font Caballero et Bisiou, page 114-115.

[19] *Ibid.*, page 116.

[20] *Ibid.*, page 120

aient des caractéristiques communes. Mais ce n'est ni la substance ni le fait qu'ils soient usagers qui sont en cause : d'autres facteurs sous-jacents au développement de conduites à risque retiendront plutôt l'attention.

Certains nous ont dit que les politiques de réduction des méfaits et des risques, ou même la décriminalisation du cannabis, en «banalise » l'usage. Il ne s'agit pas de banalisation mais de normalisation. L'usage excessif de n'importe quelle substance est nocif ; toutes les substances peuvent présenter des dangers pour la santé des usagers, même le café. Normaliser l'usage et l'usager ne signifie pas pour autant banaliser. Une politique publique sur les drogues vise donc à **normaliser les usages de substances psychoactives**, c'est-à-dire à ne pas marginaliser les usagers, sans pour autant banaliser et baisser les bras et faire l'autruche devant les dangers spécifiques aux diverses substances.

Pour résumer, une **politique publique sur les substances psychoactives doit être intégrée et adaptée, cibler les usages et conduites à risque et les abus selon une approche de santé publique qui ne banalise ni ne marginalise les usages**. Pour se concrétiser, une telle politique se décline en diverses composantes.

COMPOSANTES D'UNE POLITIQUE PUBLIQUE

Les politiques publiques que nous avons décrites au chapitre précédent, ainsi que d'autres telles celle du Danemark, du Portugal, ou du Mexique pour ne donner que ces exemples, ont en commun un certain nombre d'éléments : elles relèvent d'un centre de responsabilité fort, elles favorisent l'interconnexion et la multiplicité des points de vue, elles visent à susciter un consensus national sur des objectifs clairs et mesurables, et elles s'appuient sur des outils indépendants de connaissance et d'évaluation.

Un centre de responsabilité

On peut ne pas être d'accord avec les orientations politiques de l'Office sur les drogues de la Maison Blanche (ONDCP) ; personne ne niera que ce bureau donne des orientations majeures à la politique nationale sur les drogues aux États-Unis. On peut ne pas apprécier certaine rigidité structurelle à la Mission interministérielle en France, voire critiquer sa timidité sur les débats législatifs, mais on sera d'accord aussi pour dire que la MILDT a su aiguillonner les politiques et pratiques françaises ces cinq dernières années. Chacun des États que nous avons examinés au chapitre précédent a un centre de responsabilité visible, connu, disposant d'une légitimité indéniable en même temps que des moyens d'action à la hauteur des attentes.

Il ne fait pas de doute, selon nous, que la question des drogues, en ce qu'elle ne relève pas d'une seule compétence ministérielle ni n'appartient en propre à une administration, en ce qu'elle touche à nos modes d'être en relation avec la société et

avec les autres, et dans la mesure surtout où elle exige une capacité d'intégration en même temps que de différenciation, doit être animée par une instance qui n'est pas redevable à un ministère et qui est capable d'insuffler des directions – ce qui ne signifie pas imposer des diktats – à l'ensemble des acteurs.

Interconnexion

Les politiques sur les substances psychoactives concernent tout autant les éducateurs que les thérapeutes, les policiers que les anthropologues, les diplomates que les associations locales, sans oublier les usagers. La capacité de faire des liens pour la connaissance et la compréhension suppose déjà une capacité à établir et maintenir des liens entre les spécialités, entre les administrations, avec les citoyens. C'est tout le sens de l'interconnexion dont doit être capable une politique sur les drogues.

Élaboration en commun d'objectifs partagés

Nous avons vu, aux chapitres 11 et 18 notamment, que la politique fédérale sur les drogues, en plus de manquer de rigueur et de clarté, de moyens et d'infrastructures, ne tient pas lieu d'une politique nationale. Qu'il y ait place à la spécificité des approches particulières entre les provinces et territoires qui composent la diversité canadienne, il ne faut pas douter. En même temps, pour qu'émerge peu à peu une culture commune sur les drogues, une meilleure compréhension des comportements d'usage que la capacité de comparer entre lieux géographiques est à même de susciter, et pour que les acteurs soient en mesure de bénéficier au mieux des expériences des uns et des autres, il faut qu'existent des outils pour élaborer en commun des objectifs partagés.

Au delà, la capacité à – et la volonté de – définir des objectifs, constitue le socle sur lequel s'appuie la possibilité même de déterminer si les actions menées sont en phase avec les objectifs, si elles sont efficaces, bref, d'évaluer les impacts de ce qu'on fait.

Des outils de connaissance

Une politique publique doit aussi s'appuyer sur les connaissances. C'est là ce que nous ont dit de nombreux témoins, de tous les horizons. Les pays de l'Union européenne, les États-Unis, l'Australie, se sont dotés d'outils de connaissance puissants, notamment d'observatoires des drogues et des toxicomanies. La plupart du temps autonomes par rapport à la puissance publique et indépendants du pouvoir politique, ces observatoires sont capables de mesurer l'évolution des tendances et des formes d'usage des diverses substances, de connaître les tendances émergentes et les nouveaux produits, voire d'évaluer les politiques publiques. Nous voyons mal comment le Canada peut continuer à faire l'économie d'un outil de connaissance national sur les usages de substances psychoactives.

OPTIONS LÉGISLATIVES

Et la loi alors ? La législation découle des orientations de la politique publique, elle les appuie et les complète ; elle est un moyen, non un objectif.

Les débats sur le cannabis sont hautement contaminés par les discussions autour de la décriminalisation, de la dépénalisation, de la légalisation. Mais ces termes sont souvent mal compris, d'autant qu'ils ne sont pas nécessairement clairs. Cette dernière section consiste à définir chacun des termes clés dans ce débat et à suggérer des indicateurs à partir desquels il convient d'évaluer chacune de ces options.

Clarifications terminologiques

Décriminalisation ou dépénalisation ?

Le glossaire de terminologie sur les drogues produit par l'Office des Nations Unies sur le contrôle des stupéfiants (PNUCID) donne la définition suivante de ces deux termes :

> [Traduction] «*Décriminalisation ou dépénalisation*
> *Abroger les contrôles de nature pénale et les sanctions criminelles relativement à une activité qui demeure toutefois illégale et sujette à une réglementation et à des sanctions non pénales (p.ex. sanctions administratives telles la suspension du permis de conduite).*
> *Sous l'option «prohibition avec pénalités civiles » la possession de quantités de drogues réputées pour usage personnel fait l'objet d'un traitement civil impliquant généralement une sanction de type amende, au lieu de sanctions pénales avec dossier criminel et incarcération. Les sanctions pénales les plus sévères continuent généralement de s'appliquer aux infractions les plus sérieuses de possession, vente, production ou culture selon des quantités que la loi considère comme du trafic ou des fins commerciales.* »[21]

Pour Caballero et Bisiou, la dépénalisation consiste essentiellement à retirer les drogues du champ du droit pénal. Ils distinguent entre dépénalisation totale et dépénalisation de l'usage.[22] Dans le premier cas, il n'y a plus aucune forme de contrôle, autre que les «lois du marché ». On voit combien on est éloigné de la définition proposée par le PNUCID. La dépénalisation de l'usage correspond de plus près à la décriminalisation telle qu'entendue par le rapport du PNUCID. C'est aussi la définition qu'en donne l'Observatoire européen des drogues et des toxicomanies.

---

[21] UN Office for Drug Control and Crime Prevention (2000) *Demand Reduction. A Glossary of Terms.* Vienne : auteur, page 18.

[22] Caballero et Bisiou, *op. cit.*, page 117.

La possession, ou détention, de cannabis pour usage personnel est « décriminalisée » en Allemagne, en Australie, en Espagne, en Italie, au Portugal, aux Pays-Bas. Mais la ressemblance s'arrête là, chacun de ces pays ayant donné une couleur différente à ce terme. En Australie et dans les états américains où la possession de cannabis est décriminalisée, l'acte demeure néanmoins illégal et les personnes peuvent recevoir une amende. En Allemagne, la Cour constitutionnelle a jugé que la poursuite pour possession de petites quantités de cannabis contrevenait aux droits fondamentaux et n'était pas justifiée. En Espagne et en Italie, la possession de petites quantités de cannabis n'est pas une infraction et la consommation est autorisée sauf dans les endroits publics. Toutefois, comme au Portugal, lorsqu'une personne est trouvée en possession de cannabis, elle pourra recevoir une sanction administrative (amende en Espagne et au Portugal ; suspension de permis en Italie).[23] Aux Pays-Bas, l'infraction de possession demeure dans les textes de loi mais l'usage et certaines formes de vente (les coffee shops) sont tolérées.

La décriminalisation est donc partielle dans tous les cas. Elle est parfois *de jure* comme en Espagne, en Italie ou au Portugal et dans d'autres cas *de facto* comme aux Pays-Bas ou au Danemark.

Au Canada, certains auteurs se sont prononcés en faveur de la décriminalisation du cannabis. Le texte le plus connu est probablement celui du groupe de travail sur les politiques du Centre canadien de lutte contre l'alcoolisme et les toxicomanies.[24] Dans ce texte, les auteurs identifient quatre options de « décriminalisation » :

- Des amendes en vertu de la Loi réglementant certaines drogues et autres substances (LRDS) de sorte à exclure l'emprisonnement comme sanction possible. Cette option maintient l'illégalité de la possession de cannabis et les conséquences sur le dossier criminel.
- Une infraction civile : recourant aussi à l'amende comme sanction, cette option diffère de la première en ce que la possession de cannabis n'est plus illégale en vertu de la LRDS, mais serait sanctionnée sous les dispositions de la Loi sur les contraventions;
- Les mesures alternatives (ou la déjudiciarisation) : en vertu de cette option, la possession demeure une infraction criminelle punissable mais les mesures sont suspendues si le contrevenant accepte de se soumettre à une autre forme de «traitement » ou de mesure communautaire. Les tribunaux spéciaux sur les drogues sont une forme de mesure alternative.
- La dévolution aux provinces : selon cette approche, les provinces seraient libres d'adopter les mesures de contrôle qu'elles jugent nécessaires (à l'exclusion de mesures criminelles qui sont du ressort fédéral). Il est

---

[23] Voir EMCDDA (2001) *Decriminalisation in Europe ? Recent Developments in Legal Approaches to Drug Use.* Lisbonne : auteur. Disponible en ligne à www.emcdda.org

[24] Fischer et coll., (1998) «Cannabis use in Canada : policy options for control. » *Options politiques.* Octobre.

toutefois difficile de suivre le raisonnement des auteurs sur cette approche puisqu'elle ressemble davantage à une forme de légalisation qu'à la décriminalisation.

Au Québec, le Comité permanent de lutte à la toxicomanie (CPLT) a adopté une recommandation proposant, lorsque les intervenants le jugent approprié, des mesures de déjudiciarisation.[25] Le CPLT définit la déjudiciarisation comme «l'exercice, par le procureur de la Couronne, d'un pouvoir discrétionnaire lui permettant de ne pas poursuivre le contrevenant et de recourir plutôt à des mesures de rechange. »[26] Cependant, il note aussi que la déjudiciarisation peut recevoir une définition plus large, où le pouvoir discrétionnaire est exercé en amont de la mise en accusation par le policier, en donnant au consommateur un simple avertissement. Dans son avis, le CPLT observe que :

- Les infractions liées au cannabis représentent au moins 60 % des infractions rapportées en vertu de la LRDS et que celles de possession sont les plus fréquentes.
- Le nombre d'infractions rapportées pour possession de cannabis est en hausse mais la proportion ayant entraîné des poursuites est en baisse, même si elle demeure majoritaire (environ 60 % des affaires en 1997).
- Les pratiques d'accusation et de recours aux mesures alternatives varient entre régions au Canada et au sein du Québec.
- Les peines imposées par les tribunaux sont le plus souvent des amendes.

Mais cette recommandation timide refuse d'en faire une approche systématique, allant jusqu'à associer la consommation de cannabis à des activités délinquantes ou criminelles, ou lorsque des risques sont associés à la consommation de produits présentant une forte concentration en THC, comme si le fait de consommer des alcools forts devait entraîner des mesures plus sévères que de boire du vin.

On voit bien que le terme décriminalisation est truffé de contradictions. Alors qu'on dit le retirer du champ du droit pénal, l'acte demeure toujours illégal. La sanction est moins sévère, mais il demeure qu'une sanction s'applique, sanction qui, dans certains cas, peut avoir les mêmes effets que la sanction pénale et d'être encore plus discriminatoire : le jeune ou le démuni incapables de payer l'amende risquent de se retrouver en prison plus souvent que les adultes et les personnes bien insérées socialement. C'est ce que rappelait le Dr Kendall au Comité :

> *« Si le Canada adoptait cette recommandation, nous devrions prendre des mesures pour éviter de reproduire ce qui s'est passé en Australie, où l'établissement du «programme expiatoire pour le*

---

[25] Comité permanent de lutte à la toxicomanie (1999) *Avis sur la déjudiciarisation de la possession simple de cannabis.* Montréal : CPLT.
[26] *Ibid.*, page 2.

cannabis » a eu pour effet d'élargir le « filet » parce que les policiers ont donné des contraventions à des consommateurs qu'ils avaient ignorés auparavant.
Beaucoup de contrevenants n'ayant pas payé leurs amendes ont été condamnés par le système de justice pénale, ce qui a involontairement fait en sorte que le nombre de personnes incriminées est aussi important sinon plus qu'avant l'adoption de la nouvelle mesure. » [27]

De même, malgré ses réussites, le système néerlandais de vente contrôlée de cannabis, qui est assimilé à une décriminalisation *de facto,* n'a aucun moyen de réguler la production et la distribution qui continue d'appartenir pour partie du moins au crime organisé ni d'assurer un contrôle de qualité et notamment de la concentration en THC.

Selon certains auteurs, la décriminalisation n'est en fait qu'une forme de « prohibition moins sévère. »[28] Autrement dit, sous une apparence de mesure socialement responsable et rationnelle, c'est encore la logique de la prohibition qui prévaut. Le fond ne change pas, seulement la forme. On n'aura pas plus de capacité à faire de la prévention ou de l'éducation sous ce modèle que sous un modèle de prohibition. Pire peut-être, le modèle de prohibition tient un discours clair et cohérent ; on ne peut en dire autant des approches de décriminalisation.

Certains diront que la décriminalisation est un pas dans la bonne direction qui donne à une société le temps d'acculturer le cannabis, de convaincre les opposants que le chaos ne s'installe pas, d'adopter aussi des mesures efficaces de prévention. Nous pensons cependant que **cette approche est en fait le scénario du pire, privant l'État d'un outil de régulation nécessaire sur l'ensemble du processus de production, de distribution et de consommation, en même temps qu'elle transmet un double message au fond plutôt hypocrite**.

Légalisation

Le Glossaire des Nations Unies définit ce terme comme :

[Traduction] « *Légalisation*
Abroger la prohibition d'une activité auparavant illicite, p.ex. la vente ou la consommation non médicale de substances psychoactives. Cette approche ne signifie pas nécessairement l'abrogation de tous les contrôles sur cette activité (p.ex. la vente aux mineurs). » [29]

Le terme légalisation rejoint ici la notion de dépénalisation de Caballero et Bisiou avec ceci en plus qu'il ne s'en remet pas aux seules lois du marché mais accepte une forme de réglementation imposant certaines restrictions. Plus précisément :

---

[27] Dr Perry Kendall, Officier de santé de la Colombie-Britannique, témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 17 septembre 2001, fascicule 6, page 40.
[28] MacCoun, R., Reuter, P. et T. Schelling (1996) « Assessing alternative drug control regimes. » *Journal of Policy Analysis and Management.* Vol 15, no 3, page 332.
[29] UNDCP (2000) *op. cit.*, page 41.

« La légalisation contrôlée est un système qui vise à remplacer l'actuelle prohibition des drogues par une réglementation de leur production, de leur commerce et de leur usage en vue d'en limiter les abus préjudiciables à la société. (...) à la différence de la dépénalisation, elle conserve au droit pénal un rôle de prévention des abus nuisibles aux tiers, qu'il s'agisse des usagers (ivresse) ou des producteurs (contrebande). »[30]

Il n'existe pas, à l'heure actuelle, de système de légalisation contrôlée du cannabis. La Suisse s'en rapproche avec son projet de modification de la Loi sur les stupéfiants. Il en a cependant existé un certain nombre dans l'histoire, par exemple les régies de l'opium ou du kif des puissances coloniales jusqu'à la première moitié du XXe siècle.

Par contre, il existe des systèmes légalisés de fabrication, distribution, vente et consommation de produits tels l'alcool, le tabac, les médicaments psychotropes, dont il est possible de s'inspirer pour réguler l'ensemble du circuit de production du cannabis.

Réglementation

Le Glossaire des Nations Unies définit ce terme comme suit :

[Traduction] *« Réglementation*
Les règles régissant tous les aspects du contrôle des drogues promulgués par la loi. La violation de ces règles entraine des pénalités de nature pénale ou non pénale, telles les amendes et la suspension de permis, selon la gravité du délit et l'intention de l'auteur. »[31]

On peut bien jouer sur les mots, mais la réglementation est en fait une application nécessaire de toute forme de contrôle, qu'il s'agisse d'un système de prohibition ou d'un système de légalisation. N'importe quel produit de consommation humaine, depuis les automobiles que nous conduisons jusqu'aux aliments que nous mangeons, sont assujettis à certaines formes de réglementation. Contrôles de qualité, exigences environnementales, conformité aux normes industrielles, règlements sur l'accessibilité, sont autant de formes de réglementations qui sont nécessaires pour que nous ayons l'assurance que nous ne nous empoisonnerons pas en mangeant, ne conduirons pas des véhicules défectueux, ne brancherons pas des appareils dangereux.

La réglementation est la forme la plus courante de contrôle par l'État et le droit pénal intervient généralement lorsque les contrôles ont échoué ou lorsque les normes prévues n'ont pas été respectées.

Il en va de même actuellement du régime international de contrôle des stupéfiants. Et la loi canadienne porte sur les substances contrôlées. Le régime de contrôle peut aller de l'interdiction de tout usage sauf pour des fins médicales ou scientifiques (comme pour l'opium, la cocaïne ou le cannabis), à des formes moins sévères de contrôles, permettant une accessibilité à des produits même s'ils sont réputés dangereux, mais sous certaines conditions.

---

[30] Caballero et Bisiou, *op. cit.*, page 132.
[31] UNDCP (2000) *op. cit.*, page 63

Classification des régimes de politiques juridiques

Examinant les divers régimes de politiques juridiques, MacCoun, Reuter et Schilling distinguent trois types de régimes de politiques juridiques : prohibitionnistes, à accès contrôlé et réglementés, chacun pouvant prendre diverses formes. Nous reproduisons à la page suivante le tableau qu'ils ont proposé pour classifier les différents régimes.[32]

Les régimes de prohibition varient selon divers axes : selon la nature de l'activité prohibée (possession, usage, usage en public, etc.), selon la sévérité des sanctions (amendes civiles, amendes pénales, incarcération), selon l'intensité de la répression (ressources, priorité) et selon la capacité plus ou moins grande d'exercer un pouvoir discrétionnaire (déjudiciarisation, mesures alternatives, etc.). Le lecteur comprendra mieux pourquoi la décriminalisation est en fait une mesure de prohibition assouplie.

Les régimes d'accès contrôlé sont dans une zone grise entre la prohibition et la réglementation. Par certains côtés, ils ressemblent davantage aux modèles de prohibition, notamment en donnant au médecin ou au pharmacien, le pouvoir de décider plutôt que de favoriser la responsabilité individuelle de l'usager. C'est le modèle médical que critiquaient aussi bien Szasz que Caballero ou, plus près de nous, Malherbe dans son document de réflexion sur le rôle de l'éthique et de la santé publique. On voit mieux aussi pourquoi l'approche de réduction des méfaits s'inscrit dans cette zone grise, à cheval entre la prohibition et la réglementation, la prescription de méthadone ou d'héroïne pour le traitement des dépendances étant le cas de figure par excellence du pouvoir médical.

Enfin, le troisième type de modèle est le modèle réglementaire qui exerce divers types de contrôles sur le qui (qui peut acheter, restrictions aux mineurs), le quoi (les substances peuvent avoir des niveaux d'accessibilité différents), le comment (les points de vente, leur localisation, les exigences envers les producteurs et les vendeurs) et le quand (heures du jour, jours de la semaine, etc.).

---

32 Reproduit de MacCoun et coll., *op. cit.*, page 333. [Traduction]

Prohibitionniste	Prohibition pure : aucun usage possible (p.ex., cannabis)	Restrictions décroissantes
Accès contrôlé	Prescription prohibitionniste : usage pour fins médicales seulement	
	Traitement : prescription pour le traitement de la dépendance (p.ex. la méthadone)	
	Prescription réglementée : autoadministration sous ordonnance pour le soulagement de problèmes psychologiques (p.ex., le système en vigueur pour le Valium)	
Réglementaire	Licences positives : disponibilité pour tout adulte ayant une licence démontrant sa capacité à faire un usage approprié	
	Licences négatives : disponible à tout adulte qui n'a pas renoncé à ce droit en violant certaines conditions (p.ex, acte criminel)	
	Marché libre pour adultes : semblable à l'alcool	
	Marché libre : aucune réglementation (p.ex la caféine).	

Nous sommes d'avis qu'il **n'existe fondamentalement que deux régimes** : un régime axé sur la prohibition et un régime de légalisation. L'un et l'autre reposent sur une réglementation, et c'est la nature, les orientations, de cette réglementation qui leur confère leurs qualités spécifiques.

Les régimes de prohibition se distinguent en régimes de prohibition pénale ou médicale. Dans le premier cas, celui qu'on appelle parfois la prohibition pure, l'institution au centre de la décision est la justice – police et tribunaux. Dans le second cas, l'acteur au centre de la décision est le médecin. Dans l'un et l'autre cas, l'usager est considéré comme un « mineur », une personne en danger, qu'il faut protéger contre elle-même. C'est ce que d'aucuns appellent le paternalisme juridique. L'un et l'autre

seront plus ou moins stricts, plus ou moins sévères, mais reposent sur une conception selon laquelle tout usage mettant l'usager et la société à risque doit être strictement contrôlé. Dans ce cas de figure, **la décriminalisation de l'usage est une variante faible de la prohibition**, comportant au final plus de désavantages que d'avantages. Non seulement elle n'agit pas sur le circuit de la production et conserve le caractère de l'illégalité, mais elle s'interdit de surcroît une réelle éducation des usagers à des conduites responsables et rend impossibles des actions fortes de prévention. Par contre, **l'approche de réduction des méfaits est la variante forte d'un régime prohibitionniste**. Reconnaissant qu'elle ne peut rien faire pour éliminer les dommages causés par la criminalisation des marchés, elle cherche cependant à réduire les effets pervers de la prohibition sur les usagers, les plaçant au cœur de sa pratique, en mettant en place des systèmes de connaissance du contenu des drogues (pensons par exemple à l'analyse des comprimés d'ecstasy lors des raves).

Régimes de prohibition

	Acteur central	Degré de prohibition	Sévérité
Pénal	Police / Justice	Interdiction de fabrication, culture, production, vente, trafic, usage et consommation	+++
		Décriminalisation de l'usage avec traitement pénal / Déjudiciarisation	++
		Infractions civiles	+
Médical	Médecin	Usages thérapeutiques reconnus seulement	+ / -
		Traitement de la dépendance	+ / -
		Prescription générale d'un médecin	+ / -

Qu'il soit pénal ou médical, le régime de prohibition appelle une réglementation qui place la loi pénale en son cœur : tout rapport avec les drogues qui n'est pas autorisé sous le modèle médical sera puni d'une sanction pénale ou quasi-pénale.

L'autre type de régime repose sur une légalisation du cannabis. Il prend aussi diverses formes.

Régimes de légalisation

	Acteur central	Niveaux d'accessibilité	Degré de contrôle
Étatique	Collectivité	Licences d'usager	+
		Licence de production / distribution / vente	↓
Marché	Usager	Marché libre	-

Les régimes de légalisation vont de la délivrance d'une licence d'usager sous certaines conditions (par exemple ne pas avoir de dossier pénal ou avoir eu des problèmes de dépendance), au libre marché sans aucune forme de contrôle.

Critères pour une politique juridique sur le cannabis

Certaines analyses ont exploré la question de l'efficacité comparative de régimes de politique publique en termes de coûts et bénéfices, d'autres en termes des coûts sociaux. Dans le premier cas, l'analyse est impossible à faire simplement parce qu'il n'y a pas deux stratégies vraiment différentes qu'on pourrait comparer : il n'existe pas un modèle de réglementation du cannabis qu'on pourrait comparer à un modèle de prohibition. L'autre approche consiste à réfléchir aux coûts sociaux induits par les drogues selon un modèle de « coût de la maladie » qui repose sur un scénario « contre-factuel » : que se passerait-il s'il n'y avait pas consommation de cette drogue ? Mais d'une part, comme nous l'avons vu au chapitre 18, il est difficile de connaître les coûts actuels induits par le cannabis et la réponse de politique publique à son endroit, et d'autre part il est impossible de prédire quels seraient les coûts sociaux réels.

> *« La question est de savoir si la société se porterait mieux en autorisant l'usage d'une ou plusieurs nouvelles drogues. La réponse ne peut être positive que si le bien-être collectif augmente (ou que le « coût social » de la drogue diminue). Nul ne sait quel serait l'impact sur le « coût social » de la légalisation des drogues illicites. L'augmentation du niveau de consommation, les effets de substitution entre les drogues actuellement illicites, le tabac et l'alcool, la baisse des effets négatifs des drogues imputables à l'illégalité actuelle, et a fortiori, le résultat de toutes ces variations combinées sont imprévisibles. Il est impossible de prouver la supériorité de la prohibition sur la légalisation, ni d'ailleurs le contraire. »* [33]

L'hypothèse du scénario contre-factuel dans les études des coûts sociaux des drogues pose elle-même un défi de taille puisqu'elle repose sur l'idée, jamais démontrée, de l'éradication de la consommation d'une drogue. Héritier du champ de la santé où

[33] Kopp, P., et P. Fenoglio (2000) *op. cit.*, page 12.

l'on peut effectivement réfléchir à partir d'un modèle contre-factuel parce que l'on peut, dans certains cas, éradiquer ou presque une maladie – pensons par exemple aux maladies infantiles – ce modèle ne s'applique pas dans le cas des drogues, à moins de faire un exercice tellement hypothétique qu'il faut se demander s'il en vaut l'effort. C'est une chose de tenter d'identifier le plus précisément possible la diversité des coûts sociaux et économiques induits par les drogues pour réfléchir ensuite aux choix de politiques publiques ; cela en est une autre de prétendre qu'on peut les mesurer réellement.

MacCoun, Reuter et Schelling proposent deux séries de critères, les premiers tenant compte des applications spécifiques aux diverses substances, et les seconds portant sur les coûts et conséquences acceptables. Une matrice en quatre axes leur permet de distinguer :

- Le domaine des conséquences : santé de la collectivité et des usagers ; fonctionnement de la collectivité et des individus en son sein ; ordre public et sécurité ;
- Les torts potentiels sur chacun de ces domaines ;
- Ceux qui subissent ces torts (usagers, trafiquants, proches, employeurs, voisins, société) ; et enfin
- La source primaire du tort (la substance, son statut juridique, l'intervention de la justice).

Comment choisir ? Établissons tout de suite que **la décision demeure nécessairement, en bout de piste, une décision politique**. Les données épidémiologiques sur les niveaux de consommation du cannabis et empiriques sur ses effets et conséquences sont claires : le cannabis n'est pas une substance psychoactive aussi dangereuse que les politiques d'interdiction voudraient le faire croire. Les données comparatives sur les politiques publiques, quoique limitées, sont elles aussi claires : les actions menées sous le modèle prohibitionniste ne sont pas efficaces. Ceci étant, nous ne savons évidemment pas quelles seront les conséquences d'un régime alternatif, en l'occurrence de l'approche réglementaire que nous proposons. C'est précisément pourquoi nous insistons pour que toute stratégie en la matière soit clairement axée sur des impératifs de santé publique et se donne des outils pour suivre l'évolution de sa mise en œuvre.

Applications au cannabis

Nous ne disposons pas de toutes les données empiriques permettant de décider de l'ensemble des conséquences potentielles des différents régimes. Cette situation s'explique par le simple fait que, pour être en mesure de produire ces données, il faudrait avoir fait l'expérience du contrôle du cannabis sous chacun de ces régimes. Or, nous n'avons connu, depuis le début du XXe siècle, qu'un régime de prohibition plus ou moins renforcé selon les cas de figure.

Au demeurant, parions que, même si nous disposions de données empiriques, les choix demeureraient, en bout de piste, des choix politiques parce que ce sont fondamentalement des choix de politiques publiques qui, comme nous l'a démontré notre chapitre sur les principes directeurs, ne sont pas déterminés par le savoir scientifique.

Néanmoins, si nous tentons d'appliquer ces critères au cannabis, nous pensons qu'un **régime d'accessibilité réglementée** est le plus à même de réduire les conséquences négatives pour les usagers et pour la société.

	Interdiction	Accessibilité contrôlée
Conséquences sur :		
La santé	- Négation de l'usage et donc absence de distinction entre formes d'usages (usage, usage à risque, abus) - Primauté de l'abstinence d'où la difficulté de faire une prévention adaptée à la réalité - Coûts de santé reliés à la méconnaissance des formes d'usage - Absence de contrôle de qualité qui peut occasionner des problèmes - Difficulté pour les usagers à reconnaitre les usages à risque et à reconnaitre les problèmes de dépendance qui peuvent exister	- Augmentation possible du nombre d'usagers - Meilleure reconnaissance de l'usage et meilleure capacité à distinguer entre les formes d'usage - Capacité à faire une prévention qui ne soit pas axée sur l'abstinence - Possible augmentation des soins de santé pour les usagers excessifs suite à une augmentation du nombre d'usagers - Possibilité de contrôler la qualité ainsi que le contenu en THC - Outils de dépistage des conduites à risque et formes de traitement non pénalisantes
Fonctionnement de la société et des individus	- Meilleur rendement individuel (scolaire, professionnel) si la prohibition est entièrement réussie et s'il n'y a pas de substance de remplacement - Mise en contact des usagers avec des réseaux potentiellement criminalisés - Atteinte aux droits des personnes - Diminution théorique de la disponibilité de la substance - Augmentation théorique du prix de la substance	- Possibilité d'une augmentation de certaines conséquences négatives sur les usagers et leur entourage si le niveau de consommation augmente - Accessibilité légale de la substance qui normalise et démystifie - Élimination des conséquences négatives de la criminalisation sur les usagers - Contrôle des prix et de la disponibilité - Nécessité de contrôler la conduite avec facultés affaiblies - Nécessité de maintenir des interdictions relatives à la vente aux mineurs

Ordre public et sécurité	- Augmentation de la criminalité organisée - Trafics illégaux importants - Perte de respect pour la loi - Violence dans les milieux criminalisés	- Diminution de la criminalité organisée - Contrôle accru du trafic illégal - Augmentation possible du sentiment d'insécurité des résidents près des points de vente

Nous sommes tout à fait conscients que, pour ce qui est du régime réglementaire, nos énoncés sont tout à fait théoriques. Nous pensons toutefois que l'ensemble des données que nous avons recueillies sur le cannabis et ses dérivés justifie notre conclusion générale à l'effet que **la réglementation de la production, de la distribution et de la consommation de cannabis, pour autant qu'elle s'inscrive dans une politique publique intégrée et adaptée, est la mieux à même de répondre aux principes d'éthique axée sur l'autonomie, de gouvernance favorisant l'agir responsable et de limitation du droit pénal aux actes qui causent un préjudice démontrable à autrui. Un régime de réglementation sur le cannabis devrait permettre notamment :**

- **De cibler plus efficacement les trafics illégaux et de diminuer le rôle du crime organisé.**
- **De mener des programmes de prévention plus adaptés à la réalité et plus à même de prévenir et dépister les conduites à risque.**
- **De mieux contrôler les produits, leur qualité et leurs propriétés.**
- **De mieux informer et éduquer les usagers.**
- **De respecter les libertés individuelles et collectives et de mettre la loi en phase avec le comportement des Canadiens.**

Nous sommes d'avis que la société canadienne est prête pour une politique responsable de réglementation du cannabis pour autant qu'elle respecte ces principes fondamentaux.

CONCLUSIONS ET RECOMMANDATIONS

Le Comité spécial du Sénat sur les drogues illicites avait pour mandat d'examiner l'approche de politique publique canadienne an matière de cannabis, son efficacité et ses impacts, à la lumière des connaissances sur les effets sociaux et sanitaires du cannabis et du contexte international. Au cours des deux dernières années, nous avons entendu des experts canadiens et étrangers et revu une imposante somme de travaux de recherche scientifique, nous avons cherché à saisir l'état de l'opinion et des attitudes de nos concitoyens, nous avons réfléchi sur des principes directeurs susceptibles d'orienter une politique publique sur les drogues illicites, sur le cannabis en particulier. Notre rapport a tenté de faire le point sur l'état des connaissances et des pratiques, proposant au fil des chapitres un certain nombre de conclusions.

Nous dégageons ici les principales conclusions qui émergent de l'ensemble de ces informations, et présentons les recommandations qui en découlent, traduisant ainsi la thèse fondamentale qui sous-tend notre rapport, à savoir : ***dans une société libre et démocratique qui reconnaît fondamentalement mais non exclusivement la primauté du droit comme source de règles normatives, et où la puissance publique doit le plus possible favoriser l'autonomie et conséquemment utiliser avec parcimonie les outils de contrainte, une politique publique sur les substances psychoactives doit s'articuler sur des principes directeurs respectant la vie, la santé, la sécurité et les droits et libertés de chaque individu qui, naturellement et légitimement, recherche son bien-être et son épanouissement, et a la capacité de reconnaître la présence, la différence et l'équivalence de l'autre.***

IL Y A TRENTE ANS, LE DAIN

Il y a maintenant trente ans, la Commission Le Dain rendait public son rapport sur le cannabis. Cette Commission royale disposait de moyens autrement plus importants que les nôtres. Par contre, nous disposions d'une base de connaissances nettement plus élaborée ainsi que du recul additionnel que nous donnent ces trente ans.

La Commission avait conclu que la criminalisation du cannabis n'avait reposé sur aucun fondement scientifique. Trente ans plus tard, nous pouvons réaffirmer sa conclusion et ajouter que la continuation de la criminalisation du cannabis ne se justifie toujours pas au regard des données scientifiques sur sa dangerosité.

La Commission avait entendu et étudié les mêmes arguments sur la dangerosité du cannabis : apathie, perte d'intérêt et de concentration, difficultés d'apprentissage. Certains commissaires, pour la majorité, avaient conclu que ces préoccupations, sans être prouvées, justifiaient une politique restrictive. Trente ans plus tard, nous pouvons affirmer que les études menées depuis n'ont pas confirmé la validité de ces éléments du syndrome dit amotivationnel et ajouter que la plupart des études infirment l'existence de ce syndrome pour cause de consommation de cannabis.

La Commission avait conclu qu'on ne connaissait pas suffisamment les effets de l'usage excessif et persistant. Nous pouvons affirmer que ces formes d'usage existent, qu'elles présentent des risques pour la santé, mais que ces usages excessifs demeurent le fait d'une minorité de consommateurs. Et ajouter aussi qu'une politique publique doit se donner les moyens de prévenir et dépister les conduites à risque, ce que nos politiques n'ont pas réussi à faire jusqu'à maintenant.

La Commission avait conclu que les effets à long terme du cannabis sur les fonctions cérébrales avaient été largement exagérés mais qu'ils pouvaient affecter le développement des adolescents. Nous abondons dans le même sens, précisant que les conséquences à long terme du cannabis semblent, dans la plupart des cas, réversibles et notant de surcroît que les adolescents qui sont ou deviennent consommateurs au long cours constituent une infime minorité de ceux qui expérimentent le cannabis. Et ajoutant encore qu'une politique publique doit précisément viser à prévenir l'usage précoce ainsi que les conduites à risque.

La Commission s'était inquiétée que la consommation de cannabis ne mène à l'usage d'autres drogues. Trente ans d'expérience aux Pays-Bas montrent amplement le contraire, de même que les politiques libérales de l'Espagne, de l'Italie ou du Portugal. Et chez nous, malgré l'augmentation constante des usagers de cannabis, nous n'avons pas proportionnellement plus d'usagers de drogues dures qu'il n'y en avait à l'époque.

La Commission s'était encore inquiétée que la légalisation ne signifierait l'augmentation de la consommation, notamment chez les jeunes. Nous n'avons pas légalisé et nous détenons l'un des taux les plus élevés au monde. Les pays qui ont adopté une politique plus libérale ont pour la plupart des taux moindres que les nôtres, et ont des taux qui se sont stabilisés après une courte période d'augmentation.

Trente ans plus tard, nous constatons que :

- **Des milliards de dollars ont été engloutis dans l'application des lois sur le cannabis sans donner plus de résultats : il y a plus de consommateurs, plus d'usagers réguliers, plus d'usagers réguliers chez les adolescents**

- **Des milliards de dollars ont été engloutis dans l'application des lois sur le cannabis pour en réduire l'offre sans donner plus de résultats : le cannabis est plus disponible que jamais, cultivé à grande échelle, exporté même, grossissant les coffres et augmentant le pouvoir d'organisations criminelles**
- **Des dizaines de milliers d'arrestations et de condamnations ont été prononcées pour possession de cannabis, des milliers de personnes incarcérées, sans affecter le moindrement les tendances d'usage, mais augmentant encore davantage le fossé que la Commission avait noté entre la loi et son respect par le public.**

Il est temps de se rendre à l'évidence : nos politiques ont été inefficaces parce que ce sont de mauvaises politiques.

L'INEFFICACITÉ DES PRATIQUES ACTUELLES

Il n'y a pas, à proprement parler, de stratégie ni fédérale ni nationale. Certaines provinces ont une stratégie, d'autres non. Il y a beaucoup de bruit mais peu d'actions fortes. En l'absence d'indicateurs clairs et acceptés par l'ensemble des acteurs pour évaluer l'efficacité des politiques publiques au Canada, il est difficile de déterminer si les actions menées sont efficaces. Puisque la politique vise à réduire la demande, c'est-à-dire les taux d'usage, et l'offre en diminuant la disponibilité et poussant les prix à la hausse, on peut au moins utiliser ces deux indicateurs.

Si l'on examine les tendances d'usage de cannabis, tant chez les adultes que chez les jeunes, **force est d'admettre que nos politiques sont inefficaces**. Nous avons vu au chapitre 6 que les tendances d'usage sont en augmentation. Si nos estimations reflètent adéquatement la réalité, pas moins de 2 millions de Canadiens âgés entre 18 et 65 ans ont fait usage du cannabis au moins une fois au cours des douze derniers mois, et au moins 750 000 jeunes entre 14 et 17 ans ont fait usage du cannabis au moins une fois par mois et environ le tiers d'entre eux à chaque jour, proportions qui seraient, au moins dans les quatre provinces les plus populeuses, en augmentation. Qu'il s'agisse de l'usage ou des usages à risque, toutes les données laissent penser que l'un et l'autre sont en augmentation.

Évidemment, il faudrait être en mesure d'établir clairement si l'objectif poursuivi est l'horizon d'une société sans drogue, du moins sans cannabis, ou si l'on vise à réduire les conduites à risque et les abus. Mais là dessus, on nage en pleine confusion tant nos politiques publiques ont maintenu l'emploi de termes vagues et refusé de décider si elles sont axées sur l'abus de substances comme l'indique la terminologie anglaise de plusieurs documents ou la lutte à la toxicomanie comme le veulent les titres français.

Il y a beau jeu de condamner la « banalisation » du cannabis dans la population pour « expliquer » ces augmentations : mais il faudrait aussi savoir pourquoi cette banalisation, si tant est qu'elle se produise. Et il faudrait aussi savoir d'où proviendrait cette banalisation, tenant compte de la prégnance des discours anti-drogues. On peut blâmer les tribunaux et les juger trop laxistes : peut-être les juges ont-ils une longueur d'avance sur les responsables des politiques sur le cannabis et de l'application des lois. Il faudrait d'ailleurs savoir si les sentences sont vraiment aussi faibles que certains le prétendent. Il faudrait surtout se demander si des sentences plus sévères seraient un dissuasif efficace, sachant par ailleurs que le risque de détection par la police – que les corps policiers eux-mêmes estiment à guère plus de 10 % – est un dissuasif beaucoup plus important que la sentence. Bon an mal an, plus de 20 000 Canadiens sont arrêtés pour possession simple de cannabis seulement, et peut-être jusqu'à 50 000 selon la manière d'interpréter les statistiques. C'est déjà beaucoup trop de Canadiens pour ce type de comportement. Pourtant, rapporté au nombre d'usagers au cours des 12 derniers mois, soit environ 3 millions de personnes au total, ce sont des chiffres dérisoires. Il ne faut pas croire qu'on pourrait augmenter significativement ce nombre même en consacrant des milliards supplémentaires à la répression policière. Et il ne faut surtout pas penser qu'on devrait même tenter de le faire.

Si l'on examine la disponibilité et le prix des drogues, **il faut aussi admettre que les politiques de réduction de l'offre sont inefficaces**. Partout au Canada, et en Colombie-Britannique et au Québec plus qu'ailleurs, l'industrie du cannabis est en croissance, inondant les marchés locaux, irritant nos voisins américains, alimentant plein les coffres le monde interlope. Quant aux prix, ils ne diminuent pas soit, mais la qualité des produits augmente, notamment le contenu en THC – même si nous doutons de l'ampleur de l'augmentation qui nous a parfois été rapportée. Pourtant, les organisations policières disposent déjà de plus de pouvoirs et de latitude en matière de drogues qu'en toute autre matière pénale, plus encore depuis la tragédie du 11 septembre 2001. Pourtant, les sommes consacrées à la répression représentent déjà plus de 90 % de toutes les dépenses relatives aux drogues illicites toutes drogues confondues. Jusqu'où veut-on aller plus loin ?

Clairement, les réponses actuelles sont inefficaces. Et elles sont inefficientes. C'est un peu comme jeter l'argent des contribuables par la fenêtre au nom d'une croisade que la dangerosité du produit ne justifie pas. On nous a dit que les drogues, le cannabis inclus, ne sont pas dangereuses parce qu'illégales mais illégales parce que dangereuses. C'est peut-être vrai d'autres drogues, ce ne l'est pas du cannabis. Il faudrait qu'on se le dise une fois pour toutes et qu'on cesse de faire prendre une croisade pour la poursuite du bien public.

UNE POLITIQUE PUBLIQUE BASÉE SUR DES PRINCIPES DIRECTEURS

On peut souhaiter la santé pour tous et le bonheur au quotidien. Mais chacun d'entre nous sait combien l'un et l'autre sont fragiles. Surtout, nous savons tous que ni la santé ni le bonheur ne peuvent être imposés. Moins encore imposés par le droit criminel au nom d'une certaine idée de la morale. Quoique alléchants que puissent être les appels à une société sans drogues, et même si certains pourraient souhaiter que personne n'ait envie de fumer, de boire de l'alcool, ou de fumer un joint, nous savons en même temps que ces comportements, pour le meilleur et pour le pire, font partie de la réalité sociale et de l'histoire de l'humanité.

Quel doit alors être le rôle de l'État ? Ni abdiquer et laisser les marchés des drogues à l'état sauvage, ni non plus imposer une manière de vivre. Nous avons plutôt opté pour une conception où les politiques publiques de l'État doivent **favoriser et soutenir l'émancipation des personnes et des collectivités**. Pour certains, ce sera sûrement l'émancipation hors des drogues. Mais pour d'autres, la voie de l'émancipation peut passer par l'usage de drogues. Et pour la société dans son ensemble, cela signifie un État qui ne dicte pas ce qu'il convient d'ingurgiter et sous quelle forme. Soutenir l'émancipation signifie alors, obligatoirement, flexibilité et adaptabilité. C'est pourquoi une politique publique sur le cannabis saura être claire en même temps que tolérante, servir de guide en même temps que se retenir d'imposer une norme unique. Cette conception du rôle de l'État s'appuie sur une **éthique de l'autonomie et surtout de la responsabilité des personnes et des collectivités**. Il est effectivement beaucoup plus difficile de laisser aux personnes la capacité de prendre leurs décisions ; plus difficile parce que donnant moins l'illusion du contrôle. Mais précisément, c'est une illusion ; et nous le savons. Réconfortante peut-être à certains moments, mais susceptible de susciter combien d'excès, combien de souffrances inutiles aussi. Une éthique de la responsabilité informe sur les attentes sociales (ne pas consommer en public, ne pas vendre aux enfants), éduque sur les comportements responsables (reconnaître les conduites à risque, savoir consommer avec modération), et soutient les personnes en difficulté (en offrant un éventail de traitements).

De cette conception de l'action publique, découle un rôle restreint pour le droit pénal. En matière de cannabis, **il s'agira uniquement de proscrire les comportements qui causent un tort démontrable à autrui** : trafics illégaux, vente à mineurs, conduite avec facultés affaiblies.

Enfin, une politique publique saura tirer parti des connaissances et de la recherche scientifique sans tomber dans l'illusion scientiste comme si la science pouvait donner des réponses aux questions d'ordre politique. Oui, la connaissance a un rôle à jouer, et important, comme **outil d'aide à la décision**. Autant pour aider aux décisions de la puissance publique que celles des citoyens. Mais la science ne peut qu'être cela, et c'est bien suffisant. C'est pourquoi nous pensons qu'un observatoire des drogues et des dépendances, ainsi qu'un programme de recherches s'imposent : pour aider à la décision de ceux qui suivront après nous.

UNE STRATÉGIE FÉDÉRALE CLAIRE ET COHÉRENTE

Même si nous nous sommes concentrés sur le cannabis, nous avons été à même d'observer les faiblesses inhérentes de la stratégie fédérale en matière de substances psychoactives. À l'évidence, il n'y a pas de véritable stratégie et d'orientation d'actions. Derrière le leadership supposé de Santé Canada, se profilent en effet une absence de moyens réels d'action, un patchwork d'approches désarticulées entre les diverses substances, un éclatement aussi des actions des divers ministères. Certes, il y a des structures de coordination, mais sans des moyens véritables et des orientations claires, chacun mène ses actions selon ses priorités. Il en résulte que sont financés toute une série de programmes d'action sans que l'on puisse discerner la logique d'ensemble.

De nombreux acteurs nous ont fait part de leur désarroi devant ce puzzle dont les morceaux semblent parfois évanescents, cet empilement de décisions dont on voit mal la cohérence et qui occasionnent maintes frictions sur le terrain. Divers observateurs étrangers nous ont aussi souligné leur étonnement que le Canada, pays riche et qui n'est pas à l'abri des problématiques reliées aux substances psychoactives, n'ait pas un « champion », un porte-parole, une figure d'autorité capable de maîtriser les enjeux réels en même temps que d'obtenir une véritable concertation entre les acteurs.

C'est pourquoi nous recommandons la création d'un poste de conseiller national en matière de substances psychoactives au sein du Bureau du Conseil Privé. Il ne s'agit pas de créer une superstructure gérant l'ensemble des budgets et actions relatives aux substances psychoactives. En clair, nous envisageons une approche semblable à celle de la Mission interministérielle à la drogue et à la toxicomanie en France plutôt qu'une approche semblable à celle de l'Office pour la politique sur le contrôle des drogues aux États-Unis.

Soutenu par un petit secrétariat et par les personnels prêtés par les ministères, ce Conseiller aurait pour mandat de conseiller le Cabinet et le Premier ministre sur les questions nationales et internationales relatives aux substances psychoactives, d'assurer la coordination fédérale entre les ministères et agences, de veiller à l'élaboration et à l'atteinte des objectifs d'action du gouvernement fédéral en matière de substances psychoactives et d'agir comme porte-parole du Gouvernement canadien sur la scène internationale sur les questions relatives aux substances psychoactives.

Recommandation 1

Le Comité recommande que soit créé, au sein du Bureau du Conseil privé, un poste de Conseiller national sur les substances psychoactives et les dépendances ; que ce conseiller soit appuyé d'un petit secrétariat ; et que chaque ministère et organisme fédéral concerné par les substances psychoactives détachent auprès de ce secrétariat et à sa demande, le personnel nécessaire.

UNE STRATÉGIE NATIONALE SOUTENUE PAR DES MOYENS ET DES OUTILS

Une politique et une stratégie fédérales ne font pas une stratégie nationale. Provinces, territoires, municipalités, organismes communautaires, voire le secteur privé, y jouent un rôle, chacun selon son champ de compétences, chacun selon ses priorités. C'est nécessaire et cette diversité mérite d'être encouragée. Au même moment, il faut aussi encourager une certaine harmonisation et surtout des échanges fructueux sur les pratiques et les embûches, sur les progrès et les reculs, sur les connaissances. Hormis les actions portées à bout de bras et avec peu de moyens par le Centre canadien de lutte contre l'alcoolisme et les toxicomanies, il y a trop peu d'occasions et de mécanismes favorisant ces échanges. **L'importance des enjeux relatifs aux drogues et aux dépendances, aujourd'hui comme demain, justifie que le Gouvernement du Canada consacre des moyens et se dote des outils susceptibles de contribuer véritablement à des politiques justes, équitables et éclairées.**

Comme la plupart des observateurs canadiens et étrangers de la situation des drogues, nous n'avons pu que constater la faiblesse de nos outils et moyens de détermination et de suivi de nos objectifs de politique publique en matière de substances psychoactives. On peut ne pas être d'accord avec les objectifs chiffrés que propose l'Office américain du tsar sur les drogues pour la réduction de la consommation ou pour le nombre de programmes de traitement implantés et évalués. On peut au moins reconnaître qu'il s'agit là de balises proposées à l'ensemble des acteurs et de points de référence pour une évaluation des progrès accomplis.

On peut ne pas être tout à fait à l'aise avec la complexité du processus australien de définition d'objectifs où une grande conférence quinquennale réunit l'ensemble des partenaires des divers paliers de gouvernement, des institutions et du milieu associatif, mais on peut au moins constater que les objectifs agréés par l'ensemble des participants constituent un cadre de référence clair et permettent une meilleure harmonisation.

On peut encore penser lourde la structure de connaissance sur les tendances et modes d'usage des drogues telle qu'on la voit en Europe dans l'Observatoire européen des drogues et des toxicomanies et dans les quinze pays de l'Union, ou coûteuse la pratique américaine de mener diverses études épidémiologiques chaque année. On peut même admettre que les enquêtes menées souffrent d'un certain nombre de problèmes et sont loin de fournir une représentation parfaite des phénomènes de consommation de substances psychoactives. Mais au moins ces outils, cités internationalement, permettent à la fois de constituer une base d'information solide pour analyser les évolutions dans le temps, pour tenter de saisir l'apparition de nouveaux phénomènes de consommation et y réagir rapidement, pour évaluer la pertinence et l'efficacité des actions menées. Rien de tout cela n'existe au Canada et, parmi les pays riches de l'Occident, nous sommes les seuls à ne pas disposer d'une telle structure de connaissance.

Pour ces diverses raisons, le Comité recommande que le Gouvernement du Canada soutienne diverses actions susceptibles de permettre l'élaboration d'une

véritable stratégie nationale. Il s'agirait en premier lieu de convoquer une conférence nationale avec l'ensemble des partenaires pour fixer les objectifs et priorités d'action sur un horizon de cinq ans. Cette conférence devrait aussi identifier des indicateurs permettant de mesurer les progrès accomplis après cinq ans. En deuxième lieu, il faut refonder le Centre canadien sur l'alcoolisme et la toxicomanie. Non seulement cet organisme n'a-t-il pas de moyens, mais de surcroît il est toujours sujet aux aléas de la volonté politique du ministre de la Santé. Le Centre devrait disposer d'un budget aux dimensions des problématiques des substances psychoactives ainsi que de l'indépendance nécessaire lui permettant de mener ses travaux. Enfin, il faut aussi constituer au sein du Centre un véritable observatoire canadien des drogues et des dépendances.

Recommandation 2
Le Comité recommande que le Gouvernement du Canada mandate le Conseiller national sur les substances psychoactives et les dépendances à convoquer pour 2003 une conférence nationale de haut niveau regroupant les acteurs clés des provinces, territoires, municipalités et associations, pour fixer des objectifs et des priorités d'action en matière de substances psychoactives sur un horizon de cinq ans.

Recommandation 3
Le Comité recommande que le Gouvernement du Canada modifie la législation habilitante du Centre canadien de lutte contre l'alcoolisme et les toxicomanies pour en changer l'appellation pour *Centre canadien sur les substances psychoactives et les dépendances* ; en faire un organisme relevant du Parlement du Canada ; doter cet organisme d'un budget de fonctionnement annuel de base de 15 millions $ sujet à révision annuelle à la hausse ; exiger de cet organisme qu'il dépose au Parlement fédéral et aux Assemblées et Parlements des provinces et territoires un rapport annuel sur les actions menées, les enjeux soulevés par la pratique, la recherche et les tendances ; mandater cet organisme à assurer la coordination nationale de la recherche sur les substances psychoactives et les dépendances, et à mener certaines études sur des questions spécifiques ; et mandater le Centre à réaliser à tous les cinq ans une évaluation de la stratégie nationale en matière de substances psychoactives et de dépendances.

Recommandation 4
Le Comité recommande que le Gouvernement du Canada inclue spécifiquement dans la législation constituant le Centre canadien sur les drogues et les dépendances la création, au sein du Centre, d'un *Observatoire canadien sur les substances psychoactives et les dépendances* ; prévoit que cet Observatoire soit mandaté pour mener, à chaque deux ans, en collaboration avec les organismes pertinents, des enquêtes sur les tendances d'usage des drogues et problématiques de dépendances dans la population adulte ; assure avec les provinces et les territoires l'harmonisation des études en population étudiante et leur régularité aux deux ans ; mène des études ponctuelles sur des sujets spécifiques ; et dépose un rapport bisannuel sur les tendances d'usage et les problématiques émergentes.

UNE POLITIQUE DE SANTÉ PUBLIQUE

Lorsque le cannabis a été inclus parmi les drogues prohibées en 1923, il n'y a eu ni débat public ni discussion des effets connus de cette drogue. En fait, les opinions exprimées étaient sans commune mesure avec les dangers que pouvait représenter cette substance. Un demi-siècle plus tard, la Commission royale d'enquête sur l'usage non médical des drogues, la Commission Le Dain, avait apporté un peu plus de rationalité dans le débat sur le cannabis et fait le point sur l'état des connaissances. Ses commissaires étaient divisés non pas tant sur la nature de la drogue et de ses effets que sur le rôle de l'État et du droit pénal pour atteindre des objectifs de santé publique. Trente ans après le rapport de la Commission Le Dain, nous pouvons affirmer que, consommé de manière modérée, **le cannabis en soi présente peu de dangers pour les usagers ou pour la société, mais que certaines formes d'usage présentent des risques pour les usagers**.

Par contre, en plus d'être inefficace et coûteuse, la criminalisation actuelle entraîne une série de conséquences perverses pour les usagers qu'elle marginalise et expose au risque discriminatoire de l'arrestation et de la procédure judiciaire, pour la société en alimentant les réseaux de criminalité organisée qui profitent de la prohibition, et pour les gouvernements en diminuant leur capacité à faire une véritable prévention des usages à risque.

Ajoutons que, **même si le cannabis avait des effets négatifs importants, il faudrait s'interroger sur la pertinence d'utiliser la voie pénale pour en limiter les conséquences**. Nous avons démontré que le droit pénal n'est pas un outil de

gouvernance approprié dans les matières relevant de choix personnels et dont on sait que la prohibition s'accompagne d'effets pervers souvent plus importants que les effets positifs escomptés. Mais l'état des connaissances accumulées sur le cannabis, ses effets et ses conséquences, nous permet de ne pas avoir même à soulever cette question.

Pour autant, les données disponibles montrent qu'on ne peut plus continuer à se cacher l'ampleur du phénomène de consommation de cannabis. Nous avons vu en effet au chapitre 6 que pas moins de 30 % des Canadiens et Canadiennes (12 à 64 ans) auront expérimenté le cannabis au moins une fois au cours de leur vie, proportion qui est probablement une sous-estimation. Nous avons vu que chez les jeunes de niveau secondaire, la proportion de ceux qui ont consommé du cannabis aux cours de la dernière année avoisine les 50 %. Et pourtant, le taux de discontinuation est très élevé et la vaste majorité des expérimentateurs ne deviennent pas des usagers réguliers. Même chez les usagers réguliers, seule une faible proportion développe des problèmes objectifs de consommation excessive qui pourra inclure un certain niveau de dépendance psychologique. Les usagers ne suivent pas une trajectoire de consommation qui les mène inévitablement du moins vers le plus, mais ont plutôt des consommations en dents de scie. Les usagers réguliers tendent aussi à avoir une consommation élevée au début de la vingtaine, qui diminue ou se stabilise par la suite, et qui pour la grande majorité cesse au milieu de la trentaine.

Affirmer ce qui précède, ce n'est pas pour autant affirmer que la consommation de cannabis devrait être encouragée ni non plus qu'elle devrait faire l'objet d'un laisser-faire total. Évidemment, il s'agit d'une substance psychoactive qui a certains effets sur les fonctions cognitives et motrices. Lorsque fumé, le cannabis peut entraîner des effets nocifs sur les voies respiratoires et comporte probablement aussi un potentiel cancérogène. Chez certaines personnes vulnérables, il convient de chercher le plus possible à prévenir l'usage. C'est le cas pour les jeunes de moins de 16 ans et des personnes que certaines conditions personnelles peuvent rendre plus vulnérables (par exemple les personnes ayant des prédispositions psychotiques). Chez les usagers adultes, il convient de promouvoir une utilisation raisonnable comme on le fait pour l'alcool. Puisqu'il existe, comme pour toute substance, des usages à risque, il convient d'élaborer des mesures de prévention et des outils de dépistage et de développer les approches de traitement pour les personnes qui en font un usage excessif. Enfin, il va de soi qu'il faut dissuader la conduite sous l'influence de cannabis tant par des mesures d'éducation que par des mesures pénales sévères.

Comme pour toute autre substance, il existe des usages à risque et des usages excessifs. Il n'existe pas de critère objectif universellement admis sur les frontières entre usage, usage à risque et usage excessif. On sait que le contexte d'usage, l'âge d'initiation, la qualité du produit consommé et la quantité sont des facteurs qui interviennent dans le passage d'une forme d'usage à l'autre. Nous avons identifié, aux chapitres 6 et 7 divers critères que nous rassemblons dans le tableau que nous présentons à la page suivante.

Proposition de critères pour différencier les usages

	Contexte	Quantité	Fréquence	Durée et intensité
Expérimentation / Occasionnel	Curiosité	Variable	Quelques fois au cours de la vie	Aucune
Régulier	Récréatif, festif Surtout le soir Surtout en groupe	Quelques joints Moins d'un gramme par mois	Quelques fois par mois	S'échelonne sur quelques années mais rarement intensif
À risque	Récréatif et occupationnel (pour aller à l'école, au travail, faire du sport…) Seul, le matin Moins de 16 ans	Entre 0,1 et 1 gramme par jour	Quelques fois par semaine, le soir, les fins de semaine surtout	S'échelonne sur plusieurs années avec des pics d'intensité élevée
Excessif	Occupationnel et problèmes personnels Usages dérégulés	Plus d'un gramme par jour	Plus d'une fois par jour	S'échelonne sur plusieurs années avec une intensité élevée continue pendant plusieurs mois à la fois

Il est temps de reconnaître que si **le cannabis en soi ne représente que très peu de danger pour les usagers et pour la société, certains usages présentent des risques**. C'est pourquoi une politique publique doit **se concentrer sur la prévention des usages à risque et l'aide et le traitement aux usagers excessifs**.

Recommandation 5

Le Comité recommande que le Gouvernement du Canada adopte une *politique intégrée sur les risques et les méfaits des substances psychoactives* portant sur l'ensemble des substances (médicaments, alcool, tabac et drogues illicites). En matière de cannabis, cette politique sera axée sur l'éducation des consommateurs, la détection et la prévention des usages à risque et le traitement des usages excessifs.

UNE APPROCHE RÉGLEMENTAIRE SUR LE CANNABIS

La prohibition du cannabis **ne produit pas les bénéfices escomptés de réduction de l'usage ni des usages à problème**. Mais elle entraîne toute une série de conséquences perverses. Les usagers sont marginalisés et plus de 20 000 Canadiens sont arrêtés chaque année pour simple possession de cannabis. Dans les écoles, les jeunes ne jouissent plus des mêmes protections de leurs droits constitutionnels et civiques que les autres personnes. Les organisations criminelles bénéficient de la prohibition et augmentent leur pouvoir et leur richesse grâce à la criminalisation du cannabis. Et chacun sait que l'on n'abolira pas l'usage de drogues dans nos sociétés, du cannabis en particulier.

Certains pourront penser qu'une politique alternative consiste à baisser les bras et à renoncer à la promotion du bien-être des Canadiens et des Canadiennes. Certains pourront soutenir qu'une approche de réglementation du cannabis constituerait un affront aux valeurs fondamentales de notre société. Nous pensons au contraire que la continuation de la prohibition met la santé et le bien-être des citoyens du pays davantage en danger qu'une mise en marché réglementée du cannabis. Nous pensons que le maintien de la criminalisation est un affront aux valeurs fondamentales consacrées dans la Charte canadienne des droits et libertés et dans l'histoire de ce pays fondé sur la diversité et la tolérance.

Nous ne souhaitons pas que l'usage augmente, spécialement chez les jeunes. Mais les données que nous avons examinées aux chapitres 6 et 20 sur une base comparative montrent à l'évidence que les pays tels les Pays-Bas, l'Australie ou la Suisse ayant adopté une approche plus libérale n'ont pas vu leurs niveaux de consommation augmenter sur le long terme pour cette raison. Les mêmes données ont aussi montré clairement que des pays ayant une approche très restrictive comme la Suède et les États-Unis sont aux extrêmes en termes de niveaux de consommation, tandis que des pays ayant des approches libérales similaires comme les Pays-Bas et le Portugal sont aussi aux extrêmes entre eux et surtout sont quelque part entre la Suède et les USA. En somme, nous avons conclu que les politiques publiques en soi ont peu d'effet sur les tendances d'usage du cannabis et que d'autres facteurs, plus complexes et plus difficiles à maîtriser, interviennent davantage pour expliquer les variations.

Un régime d'exemption rendant le cannabis disponible légalement aux personnes de plus de 16 ans signifiera probablement une augmentation de la consommation pendant une certaine période. Ce niveau plafonnera ensuite, au fur et à mesure que l'intérêt s'émoussera et que les programmes de prévention efficaces seront implantés. Il suivra ensuite une tendance en dents de scie, marquée de pics et de creux, comme dans la plupart des autres pays.

Ni abdication ni à plat ventrisme, mais plutôt une vision du rôle de l'État et du droit pénal qui consistent à **susciter et favoriser l'action humaine sans la contrôler**, à **ne stipuler que les interdits nécessaires** relatifs aux principes fondamentaux du

respect de la vie et de l'autre et à la vie collective harmonieuse, et à **soutenir et aider** et non à juger et condamner la différence.

On peut souhaiter un monde sans drogues. Moins de fumeurs de tabac. Moins d'alcoolisme. Moins de dépendance aux médicaments prescrits. Mais on sait qu'on n'éliminera pas ces maux. Et surtout, on ne choisit pas de les criminaliser. C'est la même approche, la même attitude, que nous pensons la plus saine et la plus respectueuse en matière de cannabis.

C'est pourquoi nous recommandons que le Gouvernement du Canada modifie la Loi réglementant certaines drogues et autres substances afin que la production et la vente de cannabis soient exemptées des infractions criminelles sous réserve d'obtention d'une licence. Certaines conditions seront attachées à l'obtention des licences ainsi qu'à la production et à la vente, que nous avons tenté de préciser et qui se trouvent à la fin de ce chapitre afin de ne pas alourdir le texte. Notons immédiatement que nous proposons d'exclure les fabricants de cigarettes de la production et de la vente de cannabis.

Recommandation 6
Le Comité recommande que le Gouvernement du Canada modifie *la Loi réglementant certaines substances et autres drogues* dans le but de créer un régime d'exemption criminelle. Cette loi prévoira : les conditions d'obtention des licences ainsi que de production et de vente ; des sanctions pénales pour le trafic illégal et l'exportation ; et le maintien des sanctions criminelles pour toute activité ne se conformant pas au régime d'exemption.

Recommandation 7
Le Comité recommande que le Gouvernement du Canada adopte une loi d'amnistie pour toute personne condamnée pour possession simple de cannabis en vertu de la Loi actuelle et des lois précédentes.

UNE APPROCHE DE COMPASSION POUR LES USAGES THÉRAPEUTIQUES

Nous avons vu au chapitre 9 que le cannabis n'a pas été établi comme médicament au sens pharmacologique du terme. Aux difficultés inhérentes à mener des études sur les applications thérapeutiques du cannabis, s'ajoutent des difficultés tenant au contexte juridique actuel et au coût pour les gouvernements de mener des études cliniques dont on sait qu'elles sont dispendieuses.

Ceci dit, nous ne doutons pas que, dans un certain nombre de conditions médicales, et pour certaines personnes, le cannabis soit effectivement une thérapie efficace et utile. L'est-il plus que ne le seraient d'autres médicaments ? Peut-être pas. Les médecins peuvent-ils présentement prescrire en toute confiance une dose de cannabis ? Sûrement pas. Les personnes atteintes de certaines affections physiques devraient-elles avoir la possibilité d'utiliser du cannabis si elles le désirent et quand le diagnostic de leur condition a été établi par un praticien dûment reconnu ? Nous en sommes persuadés.

La réglementation adoptée en 2001 par le ministre de la Santé, si elle constitue un pas dans la bonne direction, est fondamentalement insatisfaisante. Elle ne facilite pas l'accès au cannabis thérapeutique. Elle ne tient pas compte de l'expérience et de l'expertise disponible dans les organismes de compassion. Elle est limitée à la marijuana et n'inclut pas les dérivés du cannabis tels le haschich et les huiles.

Pour ces raisons, nous recommandons que le ministre de la Santé du Canada modifie la réglementation sur l'accès du cannabis aux fins médicales afin de permettre l'accès au cannabis thérapeutique fondé sur la compassion. De même que pour la section précédente, nous avons inclus des propositions de règles à la fin de ce chapitre.

Recommandation 8

Le Comité recommande que le *Règlement sur l'accès à la marihuana à des fins médicales* soit modifié afin de prévoir des nouvelles règles concernant l'admissibilité, la production et la distribution de cannabis aux fins thérapeutiques. De plus, la poursuite de la recherche sur le cannabis thérapeutique est essentielle.

DISPOSITIONS SUR LA CONDUITE SOUS L'INFLUENCE DU CANNABIS

Nous avons vu au chapitre 8 que les effets du cannabis seul sur la conduite de véhicules n'ont pas été clairement établis par la recherche. Néanmoins, il y a suffisamment d'indications à l'effet que la conduite sous l'influence du cannabis modifie certaines capacités motrices et affecte la capacité à rester dans sa voie. Nous avons aussi vu que les effets combinés de consommation de cannabis et d'alcool diminuent les facultés davantage que l'alcool seul. Or, les enquêtes épidémiologiques montrent qu'un certain nombre d'usagers de cannabis prennent le volant sous l'influence et qu'une proportion importante, principalement chez les jeunes, semble croire que le cannabis ne diminue pas leurs facultés de conduite.

Ce chapitre avait aussi montré qu'il n'y a pas d'outil fiable et non intrusif de détection sur site. Des outils recourant à la salive sont prometteurs mais donnent pour

le moment des résultats trop instables. Par ailleurs, nous avions vu que le système de reconnaissance visuelle élaboré et évalué principalement aux États-Unis constituait un outil fiable de détection de facultés affaiblies sous l'influence de drogues.

Recommandation 9
Le Comité recommande que le Code criminel soit modifié pour abaisser le seuil d'alcoolémie à quarante milligrammes d'alcool par cent millilitres de sang lorsqu'il y a présence de drogues, notamment mais pas exclusivement de cannabis ; et pour admettre en preuve le témoignage de policiers experts formés à la reconnaissance de conduite sous l'influence de drogues.

POURSUIVRE LA RECHERCHE

La recherche sur les substances psychoactives, et tout particulièrement sur le cannabis, a véritablement explosé au cours des vingt dernières années. Le Comité a pu constater d'expérience à quel point, puisque nous avons fait face au défi d'en tenter une synthèse. Toute la recherche n'est pas de même qualité et il est vrai que le climat juridique et politique actuel sur le cannabis nuit à la rigueur et à l'objectivité des études. Nous disposons donc d'une base de connaissances solide, celle qui nous a servi à appuyer nos conclusions et recommandations précédentes.

Il demeure toutefois un certain nombre de domaines sur lesquels il conviendrait de mener davantage d'études. Au chapitre 6, nous avons vu que les connaissances sur les usages et les contextes d'usage sont limitées, faute d'études de terrain auprès des usagers. Dans la même veine, il est pour le moment difficile d'établir des critères sur les diverses formes d'usage susceptibles de guider les acteurs de prévention. Nous avons suggéré que toute consommation de plus d'un gramme de cannabis par jour est excessive, qu'une consommation entre 0,1 et 1 gramme par jour est une consommation à risque. Nous avons aussi suggéré que toute consommation chez les moins de 16 ans est une consommation à risque. Ce sont là des spéculations informées, mais des spéculations tout de même, que la recherche devrait explorer.

Nous avons aussi vu aux chapitres 16 et 17 que nous connaissons peu de choses des actions de prévention et des traitements les plus efficaces. Ici aussi, le contexte a nui. En matière de prévention, le message plus ou moins implicite du « *just say no* » et l'accent sur la prévention de l'usage ont été des stratégies dictées par un contexte de prohibition. En matière de traitement des usagers à problème, les modèles de l'abstinence ont été longtemps dominants et ils cohabitent encore mal avec des modèles de réduction des méfaits. Il y aurait lieu de mener des études d'évaluation rigoureuses.

Le Centre canadien sur les substances psychoactives et les dépendances doit jouer un rôle clé sur la coordination des études et la dissémination de leurs résultats. Le Centre n'a pas à mener les études lui-même. Elles peuvent et doivent souvent être menées par des universitaires. Les Instituts de recherche en santé sont aussi des collaborateurs évidents. Néanmoins, il importe qu'un dépositaire central de l'information issue de la recherche soit clairement identifié pour que ses résultats soient les plus largement disséminés et, souhaitons-le, utilisés.

Recommandation 10
Le Comité recommande que le Gouvernement du Canada constitue un fonds national de la recherche sur les substances psychoactives et les dépendances qui permettra de financer la recherche sur des questions clés et notamment sur les diverses formes d'usages, sur les applications thérapeutiques du cannabis, sur les outils de détection de la conduite sous influence, sur les programmes de prévention et de traitement efficaces ; et que le Gouvernement du Canada mandate le Centre canadien sur les substances psychoactives et les dépendances pour coordonner l'effort national de recherche et agir comme centre de ressources.

POSITIONNEMENT INTERNATIONAL DU CANADA

Le Comité est tout à fait conscient que le Canada, s'il choisit la voie rationnelle que le Comité lui recommande pour la réglementation du cannabis, contreviendrait ainsi aux dispositions des Conventions et Traités internationaux qui gouvernent les drogues. Nous sommes aussi conscients des implications diplomatiques de cette approche, notamment avec nos voisins américains.

Nous ne voulons pas reproduire à la frontière canado-américaine les embrouilles qui ont marqué les relations néerlandaises, françaises, belges et allemandes au cours de la période 1985-1995 sur la question du narco-tourisme. C'est un des motifs qui justifie que la distribution du cannabis et ses dérivés aux fins récréatives soit restreinte aux résidents Canadiens.

Mais nous savons qu'en ce moment même une partie importante du cannabis produit au Canada est destinée à l'exportation et que le principal «client » est notre voisin du Sud. Nous savons aussi qu'une partie importante de l'héroïne et de la cocaïne arrivant au Canada transite par les États-Unis. Nous savons surtout que ce n'est pas le cannabis canadien qui explique la montée en puissance des niveaux de consommation

aux États-Unis. Il appartient à chacun de nous de mettre de l'ordre dans sa propre maison avant de critiquer l'agencement des meubles chez l'autre.

Au plan international, le Canada devra soit se retirer temporairement des Conventions et traités soit accepter de leur être en contravention temporairement tout en demandant à la communauté internationale de les modifier. Nous optons pour la seconde approche, selon nous plus conforme à la tradition et à l'esprit de la politique étrangère canadienne. De surcroît, nous avons vu que les traités internationaux consacrent le déséquilibre des relations Nord-Sud en interdisant l'accès à des plantes, dont le cannabis, originaires du Sud, tout en bénéficiant d'un régime de réglementation pour les médicaments produits par les industries pharmaceutiques du Nord. Le Canada pourrait inviter la communauté internationale à examiner à nouveau les traités et conventions sur les substances psychoactives en ayant ce déséquilibre à l'esprit.

Par ailleurs, le Canada peut et doit jouer un rôle de leader en matière de politiques sur les drogues. Le renforcement de l'infrastructure nationale de connaissance et d'action y contribuera certainement. **Le Canada doit notamment jouer un rôle de premier plan dans les Amériques**. Nous pensons que le Canada jouit d'une réputation internationale forte et qu'il peut contribuer à l'adoption de politiques plus équitables et plus rationnelles en matière de drogues et spécifiquement de cannabis. Nous pensons entre autres que le Canada devrait stimuler la mise sur pied, au sein de l'Organisation des États Américains, d'un observatoire des Amériques sur les drogues et les dépendances qui serait le pendant de l'Observatoire européen.

Recommandation 11

Le Comité recommande que le Gouvernement du Canada instruise le ministre des Affaires étrangères et du Commerce international d'informer les autorités compétentes des Nations Unies qu'il demande la modification des Conventions et Traités réglementant les drogues illicites relativement au cannabis ; et qu'il soutienne le développement d'un Observatoire des drogues et des dépendances pour les Amériques.

PROPOSITIONS DE MISE EN ŒUVRE DE LA RÉGLEMENTATION DU CANNABIS AUX FINS THÉRAPEUTIQUES ET RÉCRÉATIVES

Modifications au *Règlement sur l'accès à la marihuana à des fins médicales* (Production et vente de cannabis aux fins thérapeutiques)

A. Personne admissible

Toute personne, qui a l'une ou l'autre des conditions physiques suivantes : cachexie, traitements de chimiothérapie, fibromyalgie et sclérose en plaque, douleurs chroniques causées par un accident ou une autre condition physique incluant les migraines et céphalées chroniques, épilepsie, dont l'état physique a été attesté par un médecin ou une personne dûment autorisée par l'association médicale compétente de la province ou du territoire, pourra exercer son libre choix de se procurer du cannabis et ses dérivés aux fins thérapeutiques. Elle devra être inscrite auprès d'un centre de distribution agréé ou de Santé Canada.

B. Licence de distribution

Tout résidant Canadien pourra obtenir une licence pour la distribution de cannabis et de ses dérivés aux fins thérapeutiques, s'il s'engage entre autres : à ne vendre que du cannabis aux fins thérapeutiques aux personnes admissibles ; à ne vendre que du cannabis et ses dérivés acheté auprès des producteurs dûment licenciés à cette fin ; à tenir des dossiers détaillés sur les conditions médicales et leur évolution, les consommations et les effets constatés sur les patients ; à prendre toutes les mesures nécessaires pour assurer la sécurité des produits du cannabis ; et à se soumettre aux inspections du ministère.

C. Licence de production

Tout résident Canadien pourra obtenir une licence pour la production de cannabis et de ses dérivés aux fins thérapeutiques s'il s'engage entre autre : à ne pas détenir une licence pour la production de cannabis non thérapeutique ; à prendre des mesures pour assurer la constance, la régularité et la qualité des récoltes ; à prendre toutes les mesures nécessaires pour assurer la sécurité des sites de production ; à connaître et documenter les propriétés et les concentrations en delta-9 THC de chaque récolte ; à ne vendre qu'aux centres de distribution agréés ; et à se soumettre aux inspections du ministère.

D. Autres propositions

- Assurer que les dépenses relatives à l'utilisation de cannabis aux fins thérapeutiques seront admissibles au crédit d'impôt pour frais médicaux ;
- Assurer la réalisation d'un programme de recherche sur les applications thérapeutiques du cannabis : en prévoyant un financement adéquat ; en mandatant le Centre canadien sur les drogues et les dépendances pour coordonner ce programme de recherches ; et en prévoyant une étude systématique de cas cliniques à partir de la documentation disponible dans les organismes qui font présentement la distribution du cannabis à des fins thérapeutiques et dans les futurs centres de distributions ;
- Assurer que le Comité consultatif sur l'utilisation thérapeutique du cannabis soit représentatif de tous les acteurs, incluant les centres de distribution et des usagers.

Modifications à la *Loi réglementant certaines drogues et autres substances* (Production et vente de cannabis aux fins non thérapeutiques)

A. But généraux du projet de loi

- Réduire les conséquences dommageables de la criminalisation de l'usage et la possession du cannabis et ses dérivés ;
- Permettre aux personnes de plus de 16 ans de se procurer du cannabis et ses dérivés dans des centres de distribution dûment licenciés ;
- Reconnaître que le cannabis et ses dérivés sont des substances psychoactives qui peuvent entraîner des risques pour la santé physique et psychologique, et à cette fin réglementer l'usage et le commerce de ces substances afin de prévenir les usages à risques et les usages excessifs.

B. Licence de distribution

Amender la Loi pour créer une exemption aux infractions criminelles prévues dans la LRDS relatives à la distribution du cannabis. Tout résident Canadien pourra obtenir une licence de distribution du cannabis à condition de s'engager entre autres : **à ne pas distribuer à des personnes de moins de 16 ans** ; **à ne vendre du cannabis et ses dérivés qu'à des résidents Canadiens** ; **à n'avoir jamais fait l'objet d'une condamnation pour infraction aux lois criminelles à l'exception des infractions relatives à la possession de cannabis pour**

lesquelles il y aura amnistie ; et à se procurer du cannabis seulement auprès des producteurs dûment licenciés. De plus, en tenant compte des limites potentielles imposées par la Charte canadienne des droits et libertés, les distributeurs licenciés ne pourront afficher les produits du cannabis de manière explicite et ne feront aucune publicité, sous aucune forme.

C. Licence de production

Amender la Loi pour créer une exemption aux infractions criminelles prévues dans la LRDS relatives à la production du cannabis. Tout résident Canadien pourra obtenir une licence de production sous conditions entre autres : de ne vendre qu'aux distributeurs dûment licenciés ; de ne vendre que de la marijuana et du haschich n'excédant pas un contenu en THC supérieur à 13 % ; de limiter sa production à ce qui est spécifié dans la licence ; de prendre toutes les mesures pour assurer la sécurité des emplacements de production ; de tenir des registres détaillés des quantités produites et des récoltes, des niveaux de concentration en THC et des conditions de production ; et de se soumettre aux inspections du ministère. Aucune personne ayant fait l'objet de poursuites et de condamnations pour infractions relatives à toute substance illicite, à l'exclusion de la possession du cannabis pour laquelle il y aurait amnistie, ne pourra se voir accorder une licence. Aucune personne physique ou morale, directement ou indirectement associée à la production, fabrication, promotion, commercialisation, ou toute autre forme d'activités reliées aux produits et dérivés du tabac. Finalement, tenant compte des limites potentielles imposées par la Charte canadienne des droits et libertés, il ne sera fait aucune publicité, sous aucune forme, des produits de cannabis et de leurs dérivés.

D. Production aux fins personnelles

Amender la Loi afin de créer une exemption aux infractions criminelles prévues dans la LRDS pour permettre la production personnelle de cannabis tant qu'il n'y aura aucune vente contre rémunération ni échange de biens en nature ou autrement et aucune publicité ou autre forme de mise en valeur de la culture. De plus, il sera prévu des limites de quantité afin d'assurer qu'il s'agit réellement de consommation personnelle.

E. Consommation en public

La consommation dans les lieux publics fréquentés par des personnes de moins de 16 ans sera prohibée.

F. Commerce international

Toute forme de commerce international sauf celles explicitement autorisées par la Loi sera soumise aux peines déjà prévues à la LRDS pour trafic illégal.

G. Autres propositions

- Assurer l'établissement d'une Régie nationale paritaire du cannabis avec les représentants dûment mandatés du Gouvernement fédéral et des Gouvernements des Provinces et des Territoires. Cette Régie tiendra un registre national de la production et de la vente du cannabis et des produits dérivés, fixera le montant et la répartition des taxes prélevées sur la vente des produits du cannabis et verra à la redistribution exclusive de la totalité des taxes prélevées sur la production et la vente de cannabis et des produits dérivés aux actions de prévention des usages à risque, de traitement des usagers excessifs, de recherche et observation des tendances, et de lutte contre le trafic illégal.
- Les provinces et les territoires continueront à élaborer les mesures de prévention qui devraient viser prioritairement les usages à risque. Le Centre canadien sur les drogues et les dépendances devrait être mandaté à colliger les meilleures pratiques de prévention et s'assurer de l'échange d'informations sur les pratiques efficaces et l'évaluation.
- Les provinces et les territoires continueront à élaborer les mesures de soutien et de traitement qui devraient viser prioritairement les usages excessifs. Le Centre canadien sur les drogues et les dépendances devrait être mandaté à colliger les meilleures pratiques de traitement et s'assurer de l'échange d'informations sur les pratiques efficaces et leur évaluation.
- Assurer le renforcement des ressources policières et douanières pour lutter contre la contrebande, l'exportation sous toutes ses formes, et le trafic transfrontalier.

BIBLIOGRAPHIE

I - RÉFÉRENCES BIBLIOGRAPHIQUES

Abt Associates. 2001. *The Price of Illicit Drugs : 1981 through the Second Quarter of 2000.* Washington (D.C.) : Office of National Drug Control Policy

Adhikari, P. et A. Summerill. 2000. *1998 National Drug Strategy Household Survey: Detailed Findings.* Canberra : Australian Institute of Health and Welfare. (Drug Statistics Series No. 6). (Disponible en ligne à l'adresse : http://www.aihw.gov.au/publications/health/ndshs98d/index.html)

Adlaf, E.M. et A. Ialomiteanu. 2000. *CAMH Monitor Report : Addiction and Mental Health Indicators among Ontario Adults, 1977-2000.* Toronto : Centre for Addiction and Mental Health.

Adlaf, E.M. et A. Paglia. 2001. *Drug Use among Ontario Students 1977-2001. Findings from the OSDUS.* Toronto : Centre for Addiction and Mental Health.

Aebi, M.F., Killias, M. et D. Ribeau. 1999. «Prescription médicale de stupéfiants et délinquance : Résultats des essais suisses ». *Criminologie* 32(2) : 127-148.

Alexander, B.K. 2000. « The globalization of addiction. » *Addiction Research.* 8(6) : 504.

Ali, R. et coll. 1998. *The Social Impacts of the Cannabis Expiation Notice Scheme in South Australia.* Canberra : Department of Health and Aged Care. (Disponible en ligne à l'adresse : http://www.health.gov.au/publhlth/publicat/drugs.htm)

Allain, J. 1997. *Projet de loi C-8 : Loi réglementant certaines drogues et autres substances.* Ottawa : Bibliothèque du Parlement – Direction de la recherche parlementaire.

Allan, Travis. 2001. « Drug Laws: the debate nobody wants ». *The Guardian.* 14 mai.

Anslinger H.J. et W. Oursler. «The War against the Murderers ». dans Walker III, W.O. (ed.). 1996. *Drugs in the Western Hemisphere: An Odyssey of Cultures in Conflict.* Wilmington (Delaware) : Scholarly Resources Inc.

Anthony J.C. et J.E. Helzer. 1991. «Syndromes of Drug Abuse and Dependence ». dans Robins, L.N. et D.A. Regier (eds.). 1991. *Psychiatric Disorders in America.* New York. Free Press : 116-154

Anthony, J.C . et coll. 1994. « Comparative Epidemiology of Dependence on Tobacco, Alcohol, Controlled Substances and Inhalants : Basic findings from the National Comorbidity Survey ». *Experimental and Clinical Psychopharmacology.* 2 : 244-268.

Aquatias. S. et coll. 1997. *L'usage dur des drogues douces, recherche sur la consommation de cannabis dans la banlieue parisienne.* Paris : OFDT.

Aquatias, S. 1999. « Usages du cannabis et situations sociales : Réflexion sur les conditions sociales des différentes consommations possibles de cannabis. » dans Faugeron, C. (ed.). 1999. *Les drogues en France.* Paris : Georg.

Ashton, C.H. 2001. « Pharmacology and Effects of Cannabis : A brief review. » *British Journal of Psychiatry.* 178 : 101-106.

Association canadienne des policiers et policières (ACP). 2001. *Mémoire présenté devant le Comité spécial du Sénat sur les drogues illicites.* Ottawa : ACP.

Ati-Dion, G. 1999. *La construction en droit international et en droit pénal canadien de la prohibition des drogues.* Montréal : Université de Montréal - École de criminologie.

Bala, N. et coll., (dir.). 2002. *Juvenile Justice Systems: An International Comparison of Problems and Solutions.* Toronto : Thompson Educational Publishing.

Barré, M.D., Pottier, M.L. et S. Delaître. 2001. *Toxicomanie, police, justice : trajectoires pénales.* Paris : OFDT.

Beardsley, R.M et coll. 1986. «Dependence on THC in rhesus monkeys ». *Journal Pharmacology and Experimental Therapeutics. Exp. Ther.* 239(2) : 311-319.

Beauchesne, Line. 1991. *La légalisation des drogues… Pour mieux en prévenir les abus.* Montréal : Méridien.

Beauchesne, Line. 1999. « À propos du cannabis, que faire? ». *L'écho-toxico.* Automne 1999. 9(2).

Belenko, Steven R. (dir.). 2000. *Drugs and Drug Policy in America: A Documentary History.* Westport (Connecticut) : Greenwood Press.

Beltrame, Julian. 2001. « Reefer Madness : The Sequel. » *MacLean's.* 114(32) : 22-25.

Bergeron, H. 1996. *Soigner la toxicomanie. Les dispositifs de soins entre idéologie et action.* Paris : L'Harmattan.

Bergeron, H. 1998. «Comment soigner les toxicomanes? », *Sociétal*, juin-juillet 1998 : 45-49.

Bernat de Celis, J. 1996. *Drogues : Consommation interdite.* Paris : L'Harmattan.

Bewley-Taylor, D.R. 1999. *The United States and International Drug Control.* London et New York : Printer.

Bigelow, G.E. 1985. *Identifying Types of Drug Intoxication: Laboratory Evaluation of a Subject-Examination Procedure.* Cité dans Sandler, D. 2000. « Expert and Opinion Testimony of Law Enforcement Officers Regarding Identification of Drug Impaired Drivers. ». *University of Hawaii Law Review* 23(1) : 150-181.

Bisiou, Y., (1999) «Histoire des politiques criminelles : Le cas des régies françaises des stupéfiants. » dans Faugeron, C., (ed.). 1999. *Les drogues en France. Politiques, marchés, usages.* Paris : Georg.

Boekhout van Solinge, T. 1997 *The Swedish Drug Control System : An in-depth Review and Analysis.* Amsterdam : Centre for Drug Research – University of Amsterdam.

Boekhout van Solinge, T. 1998. « La Politique de drogue aux Pays-Bas: un essai de changement ». *Déviance et Société.* 22 : 69 à 71.

Boggio, Y. et coll. 1997. *Apprendre à gérer : La politique suisse en matière de drogue.* Genève : Georg.

Boyd, N. 1991. *High society : Illegal and Legal Drugs in Canada.* Toronto : Key Porter Books.

Brereton, D. 2000. « The History and Politics of Prohibition ». dans Stokes, G., Chalk, P. et K. Gillen. 2000. *Drugs and Democracy: In search of new directions.* Carlton South: Melbourne University Press

British Columbia Compassion Club Society. 2001. *BCCCS Response to Health Canada's Proposed Medical Marijuana Access Regulations.* Vancouver. 4 mai 2001.

Brucker, Theresa. 2002. *The Practical Guide to the Controlled Drugs and Substances Act.* Scarborough : Carswell (Fourth Edition).

Bruun, Kettil, Pan, L et I. Rexed. 1975. *The Gentlemen's Club: International Control of Drugs and Alcohol.* Chicago : University of Chicago Press.

Bureau de la vérificatrice générale du Canada. 2001. *Rapport de la vérificatrice générale du Canada – Chapitre 11 – Les drogues illicites: le rôle du gouvernement fédéral.* Ottawa : Ministère des Travaux publics et des Services gouvernementaux.

Bureau exécutif du Président des États-Unis. 2001. *Summary: FY 2002 National Drug Control Budget.* Washington (D.C.) : Maison-Blanche.

Caballero, F. et Y. Bisiou (2000) *Droit de la drogue.* Paris : Dalloz (2e édition).

Campbell, I. 1976. " The Amotivational Syndrome and Cannabis Use with Emphasis on the Canadian Scene ". *Annals of the New York Academy of Sciences.* 282 : 33-36.

Campodònico, H. 1996. «Drug trafficking, Money and Neo-liberal Economics : Perverse effects for a developing country. » in Dorn, N. et coll. (eds.). 1996. *European Drug Policies and Enforcement.* London : Macmillan Press.

Canada. 1970. *Rapport provisoire de la Commission d'enquête sur l'usage des drogues à des fins non médicales.* (Commission Le Dain) Ottawa : Information Canada.

Canada. 1972. *Le cannabis : rapport de la Commission d'enquête sur l'usage des drogues à des fins non médicales.* (Commission Le Dain) Ottawa : Information Canada.

Canada. 1973. *Rapport final de la Commission sur l'usage des drogues à des fins non médicales.* (Commission Le Dain) Ottawa : Information Canada.

Canada. 1987. *Federal Government Launches Co-ordinated Action on Drug Abuse.* News Release.

Canada. 1987. *National Drug Strategy: Prevention, Treatment, Research, Control Components.* Ottawa : Department of Health and Welfare.

Canada. 1987. *National Drug Strategy: International Components.* Ottawa : Department of Health and Welfare.

Canada. 1987. *National Drug Strategy: Enforcement Components.* Ottawa : Department of Health and Welfare.

Canada. 1987. *National Drug Strategy: Proceeds of Crime Components.* Ottawa : Department of Health and Welfare.

Canada. 1988. *Action on Drug Abuse: Making a Difference.* Ottawa : Department of Supply and Services.

Canada. 1991. *Canada's Drug Strategy.*

Canada. 1992. *Canada's Drug Strategy – Phase II.*

Canada. 1994. *Canada's Drug Strategy – Phase II: A situation paper.* Ottawa: Santé Canada.

Canadian Medical Protective Association. 2001. *What To Do When Your Patients Apply For A Licence To Possess Marijuana For Medical Purposes.* October 2001.

Canadian Medical Protective Association. 2001. *Letter to the Honourable Allan Rock, Q.C.*, Novembre 2001.

Caplan, G.A. et B.A. Brigham. 1990. « Marijuana smoking and carcinoma of the tongue: Is there an association? ». *Cancer.* 66 : 1005-1006.

Carrier, N. 2000. *Discours de patrouilleurs montréalais sur la détection de l'infraction de possession de drogues prohibées.* Montréal : École de criminologie – Université de Montréal

Centre canadien de lutte contre l'alcoolisme et les toxicomanies. 1996. *La politique antidrogue au Canada. Mémoire au Comité permanent de la Santé de la Chambre des communes.* Ottawa : CCLAT.

Centre canadien de lutte contre l'alcoolisme et les toxicomanies. 1999. *Profil canadien : L'alcool le tabac et les autres drogues.* Ottawa : CCLAT.

Centre d'aide et d'accueil en toxicomanie (CAAT), *La mise en application de la loi.* (Disponible en ligne à l'adresse : http://caat.multimania.com/info/app_loi.htm.)

Cesoni, L.L. .1999. «Usage et actes préparatoires de l'usage des drogues illicites : les choix en matière d'incrimination. Analyse comparative de l'usage de drogues illicites de sept législations européennes. dans Conseil fédéral suisse. 2001. *Message concernant la révision de la loi sur les stupéfiants.*

Changeux, J.P. et P. Ricoeur. 1998. *Ce qui nous fait penser. La nature et la règle.* Paris : Odile Jacob.

Channabasavanna, M, et coll. 1999. « Mental and behavioural disorders due to cannabis use ». dans Kalant H. et coll. (eds.). 1999. *The Health Effects of Cannabis* , Toronto : CAMH.

Charras, I. 1998. «L'État et les stupéfiants : archéologie d'une politique publique répressive. » dans *Drogue. Du bon usage des politiques publiques.* Les cahiers de la sécurité intérieure. 32.

Chatterjee, S.K. 1988. *A Guide to the International Drugs Conventions.* Londres : Secrétariat du Commonwealth.

Chevalier, S. et O. Lemoine. 2000. «Consommation de drogues et autres substances psychoactives » dans *Enquête sociale et de santé 1998.* Québec : Institut de la statistique du Québec

Cienski, Jan et C. Hanlon. 2002. "U.S. fears drug spillover from Canada: Border seizures up dramatically in wake of Sept. 11." *National Post.* 17 mai : A 12.

Clark, P.A.. 2000. «The Ethics of Medical Marijuana : government restrictions vs. medical necessity. ». *Journal of Public Health Policy.* 21 : 40-60.

Cohen, P.D.A. et H.L. Kaal. 2001. *The Irrelevance of Drug Policy : Patterns and careers of experienced cannabis use in the population of Amsterdam, San Francisco and Bremen.* Amsterdam : University of Amsterdam (CEDRO).

Collin, C. 2001. *Politique nationale en matière de drogues : France.* Ottawa : Bibliothèque du Parlement – Direction de la recherche parlementaire. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Collin, C. 2002. *Politique nationale en matière de drogues : la Suisse.* Ottawa : Bibliothèque du Parlement – Direction de la recherche parlementaire. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Comité consultatif national d'éthique. 1994. *Rapports sur les toxicomanies.* rapport nº 43. 23 novembre 1994 : 19. (Disponible en ligne à l'adresse : http://www.ccne-ethique.org/français/start.htm)

Comité permanent de lutte à la toxicomanie. 1999. *Avis sur la déjudiciarisation de la possession simple de cannabis.* Montréal : CPLT.

Comité permanent de lutte à la toxicomanie. 2000. *Consultation 2000. La toxicomanie au Québec : Cap sur une stratégie nationale.* Québec : CPLT.

Comité permanent de lutte à la toxicomanie. 2001. *Drogues. Savoir plus. Risquer Moins.* (Édition québécoise). Montréal : Stanké.

Comité sénatorial permanent des affaires juridiques et constitutionnelles. 1996. *Onzième rapport : Projet de loi C-8, la Loi réglementant certaines drogues et autres substances.* Ottawa : Sénat du Canada.

Commission fédérale pour les questions liées aux drogues. 1999. *Rapport sur le cannabis.* Berne : Office fédéral de la santé publique.

Compton, P.R. 1986. *Field Evaluation of the Los Angeles Police Department Drugs Detection Procedure.* Cité dans Sandler, D. 2000. « Expert and Opinion Testimony of Law Enforcement Officers Regarding Identification of Drug Impaired Drivers. ». *University of Hawaii Law Review* 23(1) : 150-181.

Conseil fédéral suisse. 2001. *Message concernant la révision de la loi sur les stupéfiants.*

Convention unique sur les stupéfiants de 1961 (RTC 1964/30), modifiée par le Protocole portant amendement de la Convention unique sur les stupéfiants de 1961 (RTC 1976/48).

Convention sur les substances psychotropes de 1971, (RTC 1988/35).

Convention contre le trafic illicite des stupéfiants et des substances psychotropes de 1988, (RTC 1990/42).

Currie, D.P. 2000. *The Constitution of the United States: A Primer for the People.* Chicago : University of Chicago Press.

Curtis, C.K. 1999. *The Efficacy of the Drug Abuse Resistance Education Program (DARE) in West Vancouver Schools. Part 1 – Attitudes toward DARE : An examination of opinions, preferences, and perceptions of students, teachers, and parents.* GRC West Vancouver.

De Koninck, Thomas. 2002. *Le rôle des savoirs et de la culture dans la politique publique sur les drogues illicites.* Québec : Université Laval - professeur de philosophie. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

De Kort, M. 1994. « A Short History of Drugs in the Netherlands. » dans Leuw, E. and I. Haen Marshall (eds.). 1994. *Between prohibition and legalization. The Dutch experiment in drug policy.* Amsterdam : Kugler.

Déclaration de la Conférence sur l'abus et le trafic illicite de drogues et Schéma multidisciplinaire complet pour les activités futures de lutte contre les drogues, document de l'ONU ST/NAR/14, 1988.

Department of Justice – United States of America. 1990. *Correctional Population in the United States Prisoners in 1989.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice of United States of America. 1991. *Correctional Population in the United States Prisoners in 1990.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1992. *Correctional Population in the United States Prisoners in 1991.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1992. *Jail Inmates 1990.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1993. *Correctional Population in the United States Prisoners in 1992.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1994. *Correctional Population in the United States Prisoners in 1993.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1995. *Jail and Jail Inmates 1993-1994.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States – America. 1995. *Correctional Population in the United States Prisoners in 1994.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1996. *Correctional Population in the United States Prisoners in 1995.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1998. *Prisoners in 1997.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 1999. *Prisoners in 1998.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 2000. *Prisoners in 1999.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America. 2000. *Correctional Population in the United States Prisoners in 1997.* Washington (D.C.): Bureau of Justice Statistics Bulletin.

Department of Justice – United States of America – Drug Enforcement Administration. 2001. « Notice: Denial of Petition ». 18 avril 2001. dans 66(75) du registre fédéral : 20037-20076.

Devane, W.A. et coll. 1992. « Isolation and structure of a brain constituent that binds to the cannabinoid receptor ». *Science.* 258 (5090) : 1946-1949.

Direction de la Santé publique. 1997. *Les inégalités sociales de la santé. Rapport annuel 1998 sur la santé de la population.* Montréal : Régie régionale de la santé et des services sociaux de Montréal-Centre.

Dolin, B. 2001. *Politique nationale en matière de drogues : les Pays-Bas.* Ottawa : Bibliothèque du Parlement – Direction de la recherche parlementaire. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Dolin, B. 2002. *Politique nationale sur les drogues : les États-Unis.* Ottawa : Bibliothèque du Parlement – Direction de la recherche parlementaire. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Donald, P.J. 1991. «Marijuana and upper aerodigestive tract malignancy in young patients ». dans Nahas, G. et C. Latour (eds.). 1991. *Physiopathology of Illicit Drugs: Cannabis, Cocaine, Opiates.* Oxford : 39-54.

Donald, P.J. 1991. « Advanced malignancy in the young marijuana smoker ». dans Friedman, H. et coll., (eds.). 1991. *Drugs of Abuse, Immunity and Immunodeficiency.* London. 33-36.

Dorn, N. et A. Jamieson. 2001. *European Drug Laws : The Room for Manoeuvre.* London : DrugScope.

Doyle, C. 2000. *Drug Offences: Maximum Fines and Terms of Imprisonment for Violation of the Federal Controlled Substances Act and Related Laws.* Washington (D.C.) : Library of Congress – Congressional Research Service.

DrugScope. 2001. *United Kingdom. Drug Situation 2000.* Report to the EMCDDA. London : Drugscope.

Dubois, François. 2002. *Le Parlement fédéral et l'évolution de la législation canadienne sur les drogues illicites.* Ottawa : Comité spécial du Sénat sur les drogues illicites. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Duke, Stephen B. 1995. « Commentary: Drug Prohibition: An Unnatural Disaster ». 27 *Conn. L. Rev.* 571.

DuPont, R.L. 1999. «Examining the Debate on the Use of Medical Marijuana. » *Proceedings of the Association of American Physicians.* 111(2) : 169.

Dupras, Daniel. 1998. *Les obligations internationales du Canada en vertu des principales conventions internationales sur le contrôle des drogues.* Ottawa : Bibliothèque du Parlement – Direction de la recherche parlementaire. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Editorial. 1997. « Decriminalizing Drugs ». *Ottawa Citizen.* 12, 14, 15, et 16 avril 1997.

Ehrenberg, A. 1995 *L'individu incertain.* Paris : Calman Lévy.

Ehrlich, S. 2000. « The Increasing Federalization of Crime ». 32 *Ariz. St.L.J.* 825.

ElSohly, M.A., et coll. 2000 «Potency trends of delta9-THC and other cannabinoids in confiscated marijuana from 1980-1997 ». *Journal of Forensic Sciences.* 45(1) : 24-30.

EMCDDA. 2001. *Decriminalisation in Europe ? Recent Developments in Legal Approaches to Drug Use.* Lisbonne : EMCCDDA.

Erickson, P. et B. Fisher. 1995. *Canadian Cannabis Policy: The Impact of Criminalization, the Current Reality and Future Police Options.* Bremen. Germany. Document présenté a l'*International Symposium on Cannabis Policy, Criminal Law and Human Rights.* (Du 5 au 7 octobre 1995).

European NGO Council on Drugs and Development. 2001. *A Snapshot of European Drug Policies : Report on the state of drug policies in 12 European countries*, octobre 2001.

Fant, R.V. et coll. 1998. « Acute and residual effects of marijuana in humans. » *Pharmacology, Biochemistry and Behavior.* 60 : 777-784.

Fergusson, D.M. et L.J. Horwood. 2000. «Cannabis use and dependance in a New Zealand birth cohort. ». *New Zealand Medical Journal.* 113 : 156-158.

Fischer, B. et coll. 1998. « Cannabis use in Canada : policy options for control ». *Options politiques.* 19 : 34-38.

Fligiel, S.E.G. et coll. 1988. « Pulmonary pathology in marijuana smokers ». dans Chesher G. et coll. (eds.). 1988. *Marijuana: An International Research Report.* (National Campaign Against Drug Abuse – Monograph 7 : 43-48). Canberra : Australian Government Publishing Service.

Fligiel, S.E.G. et coll. 1997. « Tracheo-bronchial histopathology in habitual smokers of cocaine, marijuana or tobacco ». *Chest.* 112: 319-326.

Focus on the Family. 2002. *Mémoire soumis au Comité spécial du Sénat sur les drogues illicites*. Richmond (Colombie-Britannique).

Fontana, James A. 1997. *The Law of Search and Seizure in Canada.* Toronto : Butterworths (Fourth Edition).

Fried, P.A. 1995. « Prenatal exposure to marijuana and tobacco during infancy, early and middle childhood : Effects and attempts at a synthesis. ». *Archives of Toxicology.* 17.

Fried, P.A. et B. Watkinson. 1999. « 36- and 48-month neurobehavioral follow-up of children prenatally exposed to marijuana, cigarettes and alcohol ». *Journal of Deviant Behavior and Pediatrics.* 11 : 49-58.

Friman, H. Richard. 1996. *NarcoDiplomacy: Exporting the U.S. War on Drugs*, Ithaca (N.Y.) : Cornell University Press.

Gaoni, Y et R. Mechoulam. 1964. « Isolation, structure and partial synthesis of an active constituent of hashish. ». *Journal of the American Chemistry Society.* 86 : 1646-1647.

Gardner, D. 2000. « Why the war on drug has failed : Uncle Sam's war ». *Ottawa Citizen.* 5 septembre.

Gendarmerie royale du Canada. 1999. *Rapport annuel.* Ottawa : Canada.

Gendarmerie Royale du Canada. 2000. *Situation au Canada – Drogues illicites (1999).* Ottawa : Direction des renseignements criminels – GRC.

Gendarmerie Royale du Canada. 2002. *Situation au Canada – Drogues illicites (2001).* Ottawa : Direction des renseignements criminels – GRC.

Giffen, P.J., Endicott, S. and S. Lambert. 1991. *Panic and Indifference: The Politics of Canada's Drug Laws*, Ottawa: Centre canadien de lutte contre l'alcoolisme et les toxicomanies.

Gilmore, W. 1990. *Combating International Drugs Trafficking: The 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, Londres : Secrétariat du Commonwealth

Goetz, David. 2001. *La prohibition des drogues et la Constitution.* Ottawa : Bibliothèque du Parlement – Direction de la recherche parlementaire. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Goodrich, Leland M. 1960. « New Trends in Narcotics Control ». *International Conciliation.* 530.

Grapendaal, M., Leuw, E., et H. Nelen. 1995. *A World of Opportunities: Life-Style and Economic Behaviour of Heroin Addicts in Amsterdam.* New York : S.U.N.Y. Press. Cité dans Boekhout van Solinge, T. 1999. « Dutch Drug Policy in a European Context ». *Journal of Drug Issues.* 29(3) : 511. (Disponible en ligne à l'adresse : www.cedro-uva.org/lib/boekhout.dutch.html)

Greater Toronto Area Combined Forces Special Unit. 2002. *Fact Sheet – Heroin.* (Disponible en ligne à l'adresse : www.cfseu.org/heroin.html)

Greene, J. et V. Schiraldi. 2002. *Cutting Correctly : New Prison Policies for Times of Fiscal Crisis.* Washington (D.C.) : The Justice Policy Institute. (Disponible en ligne à l'adresse : www.cjcj.org)

Grinspoon, L. et J.B. Bakalar. 1997. *Marijuana: The Forbidden Medicine.* New Haven et Londres : Yale University Press.

Gurley, R.J., Aronow, R. et M. Katz. 1998. « Medicinal marijuana : A comprehensive review. ». *Journal of Psychoactive Drugs.* 30(2) : 139.

Hall, W. 1987. « A simplified logic of causal inference ». *Australian and New Zealand Journal of Psychiatry.* 21 : 507-513.

Hall, W. et N Solowij. 1998. « Adverse effects of cannabis ». *The Lancet*. 352(9140) : 6

Hamel, D. et coll. 2001. *Perceptions de la population québécoise en lien avec les programmes de prévention de la toxicomanie et du VIH*. Québec : Institut national de santé publique du Québec.

Hanak, C. et coll. 2002. « Cannabis, mental health and dependence. » dans Pelc, I. (ed.). 2002. *International Scientific Conference on Cannabis*. Brussels.

Haney, M. et coll. 1999. « Abstinence symptoms following smoked marijuana in humans » *Psychopharmacology*. 141 : 395-404.

Hansard, Chambre des communes, 10 juillet 1908.

Hansard, Chambre des communes, 26 janvier 1911.

Hansard, Chambre des communes, 23 avril 1923.

Hansard, Chambre des communes, 1932.

Hansard, Chambre des communes, 24 février 1938.

Hansard, Sénat, 24 février 1955.

Hansard, Sénat, 23 juin 1955.

Hansard, Chambre des communes, 30 mai 1961.

Hansard, Chambre des communes, 7 juin 1961.

Hansard, Chambre des communes, 27 mars 1969.

Hansteen, R.W, et coll. 1976. « Effects of cannabis and alcohol on automobile driving and psychomotor tracking ». *Annals of the New York Academy of Science*. 282 : 240-256.

Hartel, C.R. 1999. « Therapeutic Uses of Cannabis and Cannabinoids. » dans Kalant, H. (ed.). 1999. *The Health Effects of Cannabis*. Toronto : Addiction Research Foundation.

Hathaway, A. D. 1997. « Marijuana and lifestyle : Exploring tolerable deviance. » *Deviant Behavior : An Interdisciplinary Journal*. 18 : 213-232.

Hathaway, A. D. 1997. « Marijuana and tolerance : Revisiting Becker's sources of control. » *Deviant Behavior : An Interdisciplinary Journal*. 18 : 103-124.

Hathaway, A.D. 2001. *Cannabis effects and dependency concerns in long-term frequent users : A missing piece of the public health puzzle*. (Mémoire soumis au Comité spécial du Sénat sur les drogues illicites. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Hawkins, D.J., Arthur, M.W. & R.F. Catalano. 1995. « Preventing Substance Abuse. ». dans Tonry, M. et D.P. Farrington (eds.). 1995. *Building a Safer Society : Strategic Approaches to Crime Prevention*. Chicago : University of Chicago Press.

Health Canada. 1996. *Evaluation of Health Canada's Contributions to Canada's Drug Strategy: Final Report.* Ottawa : Canada.

Health Canada. 1997. *Evaluation of Canada's Drug Strategy: Final Report.* Ottawa : Canada.

Health Canada. 1999. *Research Plan for Marijuana for Medicinal Purposes : A Status Report.* Ottawa : Canada.

Health Canada. 2000. *Minister Rock announces intention to develop new approach for the use of marihuana for medical purposes.* Ottawa. News Release. 14 septembre 2000.

Health Canada. 2001. *Marijuana Medical Access Regulations - Regulatory Impact Analysis Statement*. Ottawa : Canada.

Health Canada. 2001. *Marijuana Medical Access Regulations – Amendments Resulting from Public Consultations.* Ottawa : Canada.

Health Canada. 2001. *Medical Access to Marijuana – How the Regulations Work.* Ottawa : Canada.

Henrion, R. 1995. *Rapport de la Commission de réflexion sur la drogue et la toxicomanie.* (Rapport au ministère des Affaires sociales, de la Santé et de la Ville). Paris : La Documentation française.

Home Affairs Committee. 2001. *Evidence to Home Affairs Committee Inquiry into Drug Policy.* Londres : Chambre des Communes (Royaume-Uni). (Disponible ne ligne à l'adresse: http://www.drugscope.org.uk/druginfo/evidence-select/evidence.htm)

House of Lords. 1998. *Ninth Report – Cannabis: The Scientific and Medical Evidence.* London : Select Committee on Science and Technology.

House of Lords. 2001. *Second Report – Therapeutic Uses of Cannabis.* London : Select Committee on Science and Technology.

Huestis, M.A. et coll. 1992. « Characterization of the absorption phase of marijuana smoking. » *Clinical Pharmacology and Therapeutics.* 52 : 31-41.

Inciardi, James A. 1986. *The War on Drugs: Heroin, Cocaine, Crime, and Public Policy.* Palo Alto (Californie) : Mayfield Publishing Company.

Inglis, B. (1975) *The Forbidden Game: A Social History of Drugs.* Londres: Hodder et Stoughton

INSERM. 2001. *Cannabis : Quels effets sur le comportement et la santé ?* Paris : Les Éditions Inserm.

Institute of Medicine. 1982. *Marihuana and Health.* Washington (D.C.) : National Academy of Sciences.

Jackson, A.Y. 2002. *Le coût de la consommation des drogues et la politique sur les drogues.* Ottawa : Bibliothèque du Parlement – Direction de la recherche parlementaire. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Jeffery, W.K. et coll. 1996. « The involvement of drugs in driving in Canada : An update to 1994. ». *Can. Soc. Forens. Sci. J.* 29 (2) : 93-98.

Johnston, L.D. et coll. 2001. *Monitoring the future. National Survey Results of Drug Use, 1975-2000. Volume II College Students and Young Adults Ages 19-40.* Bethseda (Michigan) : NIDA.

Joseph Rowntree Foundation. 2000. *Drugs: dilemmas, choices and the law.* York : Joseph Rowntree Foundation.(Disponible en ligne à l'adresse : http://www.jrf.org.uk/knowledge/findings/foundations/N70.asp)

Joy, J.E., Watson, S.J. et J.A. Benson. 1999. *Marijuana and Medicine : Assessing the Science Base.* Washington (D.C.) : Institute of Medicine.

Kandel, D. et M. Davies. 1992. « Progression to regular marijuana involvement: Phenomenology and risk factors for near daily use ». dans Glantz, M. and R. Pickens (eds.). 1992. *Vulnerability to Drug Abuse.* Washington (D.C.) : American Psychological Association. pp. 211-253.

Kandel, D. et coll. 1997. « Prevalence and demographic correlates of symptoms of last year dependence on alcohol, nicotine, marijuana and cocaine in the US population ». *Drugs, Alcohol and Dependency.* 44 : 11-29.

Keh, D.I. 1996. *Drug Money in a Changing World. Economic Reform and Criminal Finance.* Vienna : UNDCP (Technical paper nº 4.).

Keizer, Robert. 2001. *The Netherland's Drug Policy.* Mémoire soumis au Comité spécial du Sénat sur les drogues illicites.

Kilmer, B. 2002. « Do cannabis possession laws influence cannabis use ? ». dans Pelc, I. (dir.). 2002. *International Scientific Conference on Cannabis.* Bruxelles.

King, A.J.C. et coll. 1999. *La santé des jeunes : tendances au Canada. Les comportements de santé des jeunes d'âge scolaire.* Ottawa : Santé Canada.

Kokoreff, Michel. 2001. *« Politique des drogues en France, entre loi pénale et réduction des risques ».* Mémoire soumis au Comité sénatorial spécial sur les drogues illicites.

Kopp, P. et C. Palle. 1999. « Économistes cherchent politique publique efficace. » dans Faugeron, C., (ed.). 1999. *Les drogues en France.* Paris : Georg.

Kopp, P. et P. Fenoglio. 2000. *Le coût social des drogues licites (alcool et tabac) et illicites en France.* Paris : OFDT.

Kosten, T.R. et al. 1987. « Substance-use disorders in DSM-III-R. ». *British Journal of Psychiatry.* 151 : 8-19.

Kouri, E.M. et coll. 2000. « Abstinence symptoms during withdrawal from chronic marijuana use ». *Experimental and Clinical Psychopharmacology.* 8 : 483-492.

Krajewski, Krzysztof. 1999. « How flexible are the United Nations drug conventions? ». *International Journal of Drug Policy.* 10 : 329-338.

Kuševic, Vladimir. 1977. « Drug Abuse Control and International Treaties ». *Journal of Drug Issues.* 7(1) : 35-53.

Labrousse, A. et A. Wallon. 1993. *La Planète des drogues : organisations criminelles, guerres et blanchiment*. Paris : Seuil.

Labrousse, A. 1998. «L'approvisionnement des marchés des drogues dans l'espace Schengen. » *Les Cahiers de la Sécurité Intérieure*. 32.

Labrousse, A. 2000. *Drogues. Un marché de dupes.* Paris : Éditions alternatives.

Labrousse, A. et L. Romero. 2001. *Rapport sur la situation du cannabis dans le RIF marocain.* Paris : OFDT.

Lafrenière, G. 2001. *Politique nationale en matière de drogue : le Royaume-Uni.* Ottawa : Bibliothèque du Parlement – Direction de la recherche parlementaire. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Lafrenière, G. 2001. *Politique nationale sur les drogues : la Suède.* Ottawa : Bibliothèque du Parlement – Direction de la recherche parlementaire. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Lafrenière, G. 2001. *Les pouvoirs de la police et les infractions liées à la drogue.* Ottawa : Bibliothèque du Parlement – Direction de la recherche parlementaire (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Landry, Michel. 2001. *L'impact des traitements offerts au Québec aux personnes toxicomanes.* Mémoire présenté au Comité spécial du Sénat sur les drogues illicites.

Leduc, D., Miller-Chenier, N. et S. Norris (2001) *Inventaire de la recherche fédérale sur les drogues illicites et les questions connexes.* Ottawa : Bibliothèque du parlement – Direction de la recherche parlementaire. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Leduc, D., Miller Chenier, N. et S. Norris (2002) *Inventaire de la recherche provinciale et territoriale sur les drogues illicites et les questions connexes.* Ottawa : Bibliothèque du Parlement – Direction de la recherche parlementaire. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Léger Marketing. 2002. *Étude exploratoire auprès des Canadiens sur l'usage du cannabis.* Montréal : Léger Marketing. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Leiter, Richard A. (dir.). 1999. *National Survey of State Laws, 3rd Ed.* Detroit : Gale Group. (3e édition)

Leland M. Goodrich. 1960. « New Trends in Narcotics Control », *International Conciliation*, No 530

Lettre de Mme Kathy Bedard, Prince Rupert, Colombie-Britannique, 15 mai 2002.

Lipton, D.S. 1995. *The Effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision.* Washington (D.C.) : National Institute of Justice.

Lowes, P.D. 1966. *The Genesis of International Narcotics Control.* Genève : Droz.

Luna, E.G. 1997. « Our Vietnam: The Prohibition Apocalypse », *Depaul L. Rev.* 46 : 483.

MacCoun, R., Reuter, P. et T. Schelling. 1996. « Assessing alternative drug control regimes. » *Journal of Policy Analysis and Management.* 15 (3).

MacDonald, Roederick A. 2002. *La gestion publique des humains.* Montréal : Univerité McGill – professeur de droit constitutionnel. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

MacFarlane, B. A., Frater, R. J. et C. Proulx. 1996. *Drug Offences in Canada.* Ontario : Canada Law Book.

MacKay, R. 2001. *Politique nationale sur les drogues : l'Australie.* Ottawa : Bibliothèque du Parlement. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Mackenzie King, William L. 1908. *Rapport sur la nécessité de supprimer le commerce de l'opium au Canada.* Ottawa : Chambre des communes (Document parlementaire 36b).

MacPhee, D. 1999. « Effects of marijuana on cell nuclei », in Kalant, H. et coll. (eds.). 1999. *The Health Effects of Cannabis*, Toronto : Addiction Research Foundation.

Maillet A. et C. Cloutier-Vautour. 2002. *Mémoire soumis au Comité spécial du Sénat sur les drogues illicites.* Moncton.

Malherbe, J.F. 2002. *Contribution de l'éthique à la définition de principes directeurs pour une politique publique sur les drogues illicites.* Sherbrooke : Université de Sherbrooke - professeur - *Chaire d'éthique appliquée.* (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Mangham, Colin. 2001. *Conséquences de la libéralisation de la politique antidrogue du Canada.* Mémoire soumis au Comité spécial sur les drogues illicites. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Martineau, H. et É. Gomart. 2000. *Politiques et expérimentations sur les drogues aux Pays-Bas.* Rapport de synthèse. Paris : OFDT.

Matsuda, L.A. et coll. 1990. «Structure of a cannabinoid receptor and functional expression of the cloned DNA ». *Nature.* 346(6284) : 5561-564.

McAllister, W.B. 1992. « Conflicts of Interest in the International Drug Control System », dans William O. Walker III, (ed.). 1992. *Drug Control Policy: Essays in Historical and Comparative Perspective*, University Park (Pennsylvanie) : Pennsylvania State University Press.

McAllister, W.B. 1999. *Drug Diplomacy in the Twentieth Century : An international history.* London : Routledge.

McCaffrey, B.R. 1999. *Remarks before the First Annual Criminal Justice and Substance Abuse Conference.* Albany (New York). June 29, 1999.

McDonald, D. et al. 1994. *Legislative Options for Cannabis Use in Australia*, Commonwealth d'Australie. (Disponible en ligne à l'adresse : http://www.druglibrary.org/schaffer/Library/studies/aus/cannabis.htm)

McKim, W.A. 2000. « Cannabis ». dans McKim, W.A. (ed.). 2000. *Drugs and Behavior. An introduction to behavioral pharmacology.* Upper Saddle River : Prentice Hall.

McNamara, J. D. 1999 «When Cops Become the Gangsters ». *Los Angeles Times*. 21 septembre 1999. (Disponible en ligne à l'adresse : www.nakedgov.com/mcnamara.htm)

McNamara, J.D. 2000. « Commentary : Criminalization of Drug Use ». *Psychiatric Times*. 17(9).

Mechoulam, R. et Y. Gaoni. 1965. «A total synthesis of delta-9-tetrahydrocannabinol, the active constituent of hashish. ». *Journal of the American Chemistry Society*, 87 : 3273-3275.

Meier, Kenneth J. 1994. *The Politics of Sin: Drugs, Alcohol and Public Policy*. Armonk (New York) : M.E. Sharpe.

Mercer, W.G. et W.K. Jeffery. 1995. «Alcohol, Drugs and Impairment in Fatal Traffic Accidents in British Columbia » *Accid. Anal. And Prev.* 27(3) : 335-343.

Mewett, A. W. et S. Nakatsuru. 2000. *An Introduction to the Criminal Process in Canada*. Scarborough: Carswell (Fourth Edition).

Miles, G.C. et coll. 1974. *An Experimental Study of the Effects of Daily Cannabis Smoking on Behavioural Patterns*. Toronto : Addiction Research Foundation.

Miller, M. et G. Draper. 2001. *Statistics on Drug Use in Australia 2000*. Canberra : Australian Institute of Health and Welfare. (Disponible en ligne à l'adresse: http://www.aihw.gov.au/publications/phe/sdua00/index.html)

Ministère de la Santé et des Affaires sociales. 2002. *National Action Plan on Narcotic Drugs*, Fiche d'information.

Ministerial Council on Drug Strategy. 1998. *National Drug Strategic Framework 1998-99 to 2002-03: Building Partnerships*. Canberra : Document rédigé pour le compte du *Ministerial Council par un comité directeur mixte de l'Intergovernmental Committee on Drugs et l'Australian National Council on Drugs*. (Disponible en ligne à l'adresse : http://www.health.gov.au/pubhlth/nds/resources/publist.htm)

Ministerial Council on Drug Strategy. 2001. *National Action Plan on Illicit Drugs, 2001 to 2002-03*. Canberra : Document rédigé par le *National Expert Advisory Committee on Illegal Drugs*. (Disponible en ligne à l'adresse : http://www.health.gov.au/pubhlth/nds/resources/publist.htm)

Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT). 1999. *Plan triennal de lutte contre la drogue et de prévention des dépendances (1999-2001)*. (Disponible en ligne à l'adresse : http://www.drogues.gouv.fr/uk/what_you_need/whatyouneed_intro.html)

Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT). 1999. «Livret de connaissances, Synthèse du plan gouvernemental de lutte contre la drogue et de prévention des dépendances 1999-2000-2001 ». *Drogues : savoir plus, risquer moins*. MILDT (Disponible en ligne à l'adresse : http://www.drogues.gouv.fr/fr/index.html)

Moreau de Tours, J. 1845. *Du haschich ou de l'aliénation mentale, étude psychologique*. Paris : Masson.

Moskowitz, H. 1985. « Marihuana and Driving ». *Accid. Anal. Prev.* 17 (4) : 323-345.

Munro, S. et coll. 1993. « Molecular characterization of a peripheral receptor for cannabinoids. ». *Nature.* 365 : 61-65.

Murphy, E. 1920. « The underground system. » *Maclean's.* 15 mars 1920.

Murphy, E. 1922. *The Black Candle.* Toronto : Thomas Allans.

Musto, D.F. 1999. *The American Disease: Origins of Narcotic Control.* Oxford: Oxford University Press (3e édition)

National Drug Monitor. 2000. *Fact Sheet: Cannabis Policy, Update 2000.* Utrecht : Trimbos-Instituut.

National Drug Research Institute andCurtin University of Technology. 2000. *The Regulation of Cannabis Possession, Use and Supply.* Perth (Australie-Occidentale) : Document de travail produit pour le compte du *Drugs and Crime Prevention Committee – Parliament of Victoria.*

National Institute of Public Health. 2001. *National Report : Sweden 2001.* Stockholm.

Nelson, P.L. 1993. « A critical review of the research literature concerning some biological and psychological effects of cannabis » dans Advisory Committee on Illicit Drugs (eds.) 1993. *Cannabis and the law in Queensland : A discussion paper.* Brisbane : Criminal Justice Commission of Queensland.

Nolin, P.C. 1998. Préface. In Riley, D. 1998. *La politique canadienne de contrôle des drogues. Aperçu et commentaires.* Ottawa : Sénat du Canada.

Noll, Alfons. 1977. «Drug abuse and penal provisions of the international drug control treaties ». *Bulletin on Narcotics.* 29(4) octobre/décembre 1977 : 41-57.

Note d'information du Bureau de recherche du Parti progressiste-conservateur du Canada, 1er juin 1987.

Observatoire européen des drogues et des toxicomanies (OEDT) *France Country Profile : French Drug Legislation.* European Legal Database on Drugs. (Disponible en ligne à l'adresse : http://eldd.emcdda.org/databases/eldd_national_reviews.cfm?country=FR.)

Observatoire européen des drogues et des toxicomanies. *Country Profiles – Sweden*, European Legal Database on Drugs

Observatoire français des drogues et des toxicomanies (OFDT). 2000. *Drogues et toxicomanies : Indicateurs et tendances.* Édition de 1999. (Disponible en ligne à l'adresse : http://www.drogues.gouv.fr/fr/index.html.)

Observatoire français des drogues et des toxicomanies. 2002. *Drogues et dépendances : Indicateurs et tendances 2002.* Paris : OFDT.

Observatoire géopolitique des drogues. 1996. *Atlas mondial des drogues.* Paris : PUF.

Observatoire géopolitique des drogues. 1999. *Rapport annuel 1998/1999.* Paris : OGD.

Office fédéral de la police. *Un aperçu de l'OFP.* (Disponible en ligne à l'adresse : http://www.bap.admin.ch/f/index.htm)

Office fédéral de la police. 1996. *Exploitation définitive de la banque de données en matière de drogue DOSIS*. 26 juin 1996. (Disponible en ligne à l'adresse : http://www.bap.admin.ch/f/index.htm)

Office fédéral de la police. 2001. *Situation Suisse : Rapport de situation 2000* Berne : Service d'analyse et de prévention. (Disponible en ligne à l'adresse : http://www.bap.admin.ch/f/index.htm)

Office fédéral de la santé publique. 1998. *Mesures fédérales pour réduire les problèmes de la drogue.* Document de base de l'Office fédéral de la santé publique – Décision du Conseil fédéral du 20 février 1991. Doc. nº 3.4.1f.

Office fédéral de la santé publique. 1998. *Programme de mesures de santé publique de la Confédération en vue de réduire les problèmes de drogue.* (ProMeDro). 1998-2002.

Office fédéral de la santé publique. 2000. *La politique en matière de drogue.* Septembre 2000. (Disponible en ligne à l'adresse : http://www.bag.admin.ch/sucht/f/index.htm)

Office fédéral de la santé publique. 1999. *The Swiss drug policy: A fourfold approach with special consideration of the medical prescription of narcotics.* Berne: SFOPH

Office of National Drug Control Policy. 2001. *National Drug Control Budget Executive Summary, Fiscal Year 2002.* Washington (D.C.) : The White House.

Office of National Drug Control Policy. 2002. *National Drug Control Strategy.* Washington (D.C.) : The White House.

Office of National Drug Control Policy. 2002. *National Drug Control Strategy: 2001 Annual Report.* Washington (D.C.) : The White House.

Organisation mondiale de la santé. 1952. *Comité d'experts des drogues susceptibles d'engendrer la toxicomanie*, Série des rapports techniques, Nº 57. Cité dans Caballero, F. et Y. Bisiou. 2000. *Droit de la drogue.* Paris : Dalloz (2e édition).

Organisation mondiale de la santé. 1964. *Comité d'experts des drogues engendrant la dépendance*. Série de rapports techniques, Nº 273. Cité dans Caballero, F. et Y. Bisiou. 2000. *Droit de la drogue.* Paris : Dalloz (2e édition).

Organisation mondiale de la santé. 1969. *Comité d'experts de la pharmacodépendance*, Série de rapports techniques. Nº 407. Cité in Caballero et Bisiou. 2000. *Droit de la drogue.* Paris : Dalloz.

Organe international de contrôle des stupéfiants. 1988. *Rapport de l'Organe international des stupéfiants pour 1987.* Vienne : Organisation des Nations Unies.

Organe international de contrôle des stupéfiants. 2002. *Rapport de l'Organe international de contrôle des stupéfiants pour 2001.* Vienne : Nations Unies.

Patten, D., et coll. 2000. *Substance Use among High School Students in Manitoba.* Winnipeg : Addictions Foundation of Manitoba.

Patton, D. et coll. 2001. *Substance use among Manitoba high school students.* Winnipeg : Addictions Foundation of Manitoba. (Disponible en ligne à l'adresse : www.afm.mb.ca)

Pays-Bas. 1985. *Groupe de travail interministériel sur les drogues et l'alcool.* La Haye : Ministère de la Justice.

Peith, M. 2001. *« Compatibilité de différents modèles de dépénalisation partielle du cannabis avec les conventions internationales sur les stupéfiants. ».* Avis juridique soumis à la demande de l'Office fédéral de la santé publique de la Confédération helvétique.

Pelletier, M. 1978. *Rapport de la mission d'étude sur l'ensemble des problèmes de la drogue.* Paris : La Documentation française.

Pernanen, K. et coll. 2002. *Proportions of crimes associated with alchool and other drugs in Canada.* Ottawa : Centre canadien de lutte contre l'alcoolisme et les toxicomanies.

Pires A.P. 2002. *La politique législative et les crimes à « double face » : Éléments pour une théorie pluridimensionnelle de la loi criminelle.* Ottawa : Université d'Ottawa - professeur de criminologie. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Plecas, D., Dandurand, Y., Chin, V. et T. Segger. 2002. *Marihuana Growing Operations in British Columbia – An Empirical Survey (1997-2000).* Département de criminologie et de justice criminelle – University College of the Fraser Valley and International Centre for Criminal Law Reform and Criminal Justice Policy.

Polen, M.R. 1993. «Health care use by frequent marijuana smokers who do not smoke tobacco.». *Western Journal of Medicine.* 158 : 596-601.

Police Foundation. 2000. *Drugs and the Law : Report of the Independent Inquiry into the Misuse of Drugs Act 1971.* London : The Police Foundation.

Popper, K. 1978. *Logique de la découverte scientifique.* Paris : Payot.

Popper, K. 1985. *La connaissance objective.* Bruxelles : Complexe.

Poulton, R., et coll. 2001. « Persistence and perceived consequences of cannabis use and dependence among young adults : Implications for policy ». *New Zealand Medical Journal.* 114 : 13-16.

Ramaekers, J.G. et coll. 2002. « Performance impairment and risk of motor vehicle crashes after cannabis use » dans Pelc, I. (ed.). 2002. *International Scientific Conference on Cannabis*, Bruxelles.

Real Women of Canada. 2002. *Mémoire soumis au Comité spécial du Sénat sur les drogues illicites.* (Windsor, Ontario)

Rehm, J. 2001. *The Costs of public policies to fight illegal drugs.* Mémoire présenté au Comité spécial du Sénat sur les drogues illicites.

Reinarman, C. et H. G. Levine (dir.). 1997. *Crack in America: Demon Drugs and Social Justice.* Berkeley : University of California Press.

Reuband, K.. 1995. «Drug use and drug policy in Western Europe.» *European Addiction Research.* 1 : 32-41.

Reynaud, M., Parquet, P.J. et G. Lagrue (1999) *Les pratiques addictives. Usage, usage nocif et dépendance aux substances psychoactives.* Paris : Secrétariat d'État à la Santé et aux Affaires Sociales.

Rickard, M. 2001. *Reforming the Old and Refining the New: A Critical Overview of Australian Approaches to Cannabis.* Canberra: Department of the Parliamentary Library – Information and Research Services. Rapport de recherche nº 6 2001-02. (Disponible en ligne à l'adresse : http://www.aph.gov.au/library)

Rigter, H. et M. von Laar. 2002. « The Epidemiology of cannabis use. » dans Pelc, I. (ed.). 2002. *International Scientific Conference on Cannabis.* Bruxelles.

Riley, D. 1996. *Harm Reduction : Concepts and Practice. A Policy Discussion Paper.* Ottawa: Centre canadien de lutte à l'alcoolisme et les toxicomanies.

Riley, D. 1998. *La politique canadienne de contrôle des drogues: Aperçu et commentaires.* Ottawa. Sénat du Canada

Roberts, G. et A. Ogborne. 1998. *Profil. Alcoolisme et toxicomanie : Traitement et réadaptation au Canada.* Ottawa : Santé Canada.

Robert, G. et A, Ogborne. 1999. *Meilleures pratiques – Alcoolisme et toxicomanie. Traitement et réadaptation.* Ottawa : Santé Canada.

Roberts, G. et coll. 2001. *Prévention des problèmes attribuables à la consommation d'alcool et d'autres drogues chez les jeunes. Un compendium des meilleures pratiques.* Ottawa : Santé Canada.

Robson, William. 2002. «Combien de banlieues devront flamber à cause de la lutte antidrogues ? » *Ottawa Citizen*, 17 mai 2002.

Rodriguez de Fonseca, F. et coll. 1994. «Down regulation of rat brain cannabinol binding sites after chronic delta-9-THC treatment ». *Pharm. Biochem. Behav.* 47 : 33-40.

Roques, B. 1999. *La dangerosité des drogues.* Paris : Odile Jacob.

Rosenthal, M.S. et H.D. Kleber. 1999. « Making Sense of Medical Marijuana. » *Proceedings of the Association of American Physicians.* 111(2) : 159.

Royal Commission of Inquiry into the Non-Medical Use of Drugs South Australia. 1979. *Rapport final.* Adelaïde : South Australian Government.

Russo, E.B. 2002. « The role of cannabis and cannabinoids in pain management. » dans Weiner, R.S. (ed.) 2002. *Pain Management. A Practical Guide for Clinicians.* Boca Raton, London, New York, Washington : CRC Press.

Russo, E.B., et coll. 2002. « Chronic cannabis use in the compassionate investigational new drug program : An examination of benefits and adverse effects of legal clinical cannabis. » *Journal of Cannabis Therapeutics.* 2(1) : 45.

Rydell, C. P., et S. S. Everingham. 1994. *Controlling Cocaine: Supply vs. Demand Programs.* RAND : Santa Monica (California).

Santé et bien-être social Canada. 1990. *Les drogues : Faits et méfaits.* Ottawa : Ministère des Approvisionnements et Services.

Schiraldi, V., Holman, B. et P. Beatty. 2000. *Poor Prescription : The Costs of Imprisoning Drug Offenders in the United States.* Washington, D.C. : Justice Policy Institute. (Disponible en ligne à l'adresse : www.cjcj.org)

Scholten, W.K. 2002. « Medicinal cannabis : A quick scan on the therapeutic use of cannabis ». dans Pelc, I., (ed.) 2002. *International Scientific Conference on Cannabis.* Bruxelles.

Service correctionnel du Canada. 2001. « Profil de la population de délinquants condamnés pour une infraction liée à la drogue dans le système correctionnel fédéral canadien ». *Forum – Recherche sur l'actualité correctionnelle*. 13 (3) : 25-29

Setbon, M. 2000. *L'injonction thérapeutique : Évaluation du dispositif légal de prise en charge sanitaire des usagers de drogues interpellés.* Paris : Observatoire français des drogues et des toxicomanies

Sherman, L.W. et coll. 1997. *Preventing Crime : What Works, What Doesn't, What's Promising.* (A Report to the United States Congress). Washington (D.C.) : US Department of Justice.

Simmat-Durand, L. 1999. « Les obligations de soins en France. » dans Faugeron, C., (ed.). 1999. *Les drogues en France. Politiques, marchés, usages.* Paris : Georg.

Simmat-Durand, L. 2000. *La lutte contre la toxicomanie. De la législation à la réglementation.* Paris : L'Harmattan.

Single, E., et coll. 1996. *The Costs of Substance Abuse in Canada.* Ottawa : Centre canadien de lutte à l'alcoolisme et les toxicomanies.

Single, E. et T. Rohl. 1997. *The National Drug Strategy: Mapping the Future.* Canberra : Rapport commandé par le *Ministerial Council on Drug Strategy*. (Disponible en ligne à l'adresse : http://www.health.gov.au/pubhlth/publicat/document/mapping.pdf)

Single, E., Christie P. et R. Ali. 2000. «La dépénalisaton de l'usage de cannabis en Australie et aux États-Unis : Ses effets ». *Journal of Public Health Policy*. 21(2) : 157-186. (Disponible en ligne à l'adresse : http://www.parl.gc.ca/37/1/parlbus/commbus/senate/Com-f/ille-f/presentation-f/single-f.htm)

Sinha, J. 2001. *L'historique et l'évolution des principales conventions internationales de contrôle des stupéfiants.* Ottawa : Bibliothèque du Parlement – Direction de la recherche parlementaire. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Smiley, A. 1999. «Marijuana : On-Road and Driving Simulator Studies » in Kalant, H. et coll., (ed). 1999. *The Health Effects of Cannabis.* Toronto : Addiction Research Foundation.

Smith, D.E. 1998. « Review of the American Medical Association Council on Scientific Affairs Report on Medical Marijuana. » *Journal of Psychoactive Drugs.* 30 : 127-136.

Spicer, L. 2002. *Utilisations historiques et culturelles du cannabis et le « débat sur la marijuana » au Canada.* Ottawa : Bibliothèque du Parlement – Direction de la recherche parlementaire. (Disponible en ligne à l'adresse : www.parl.gc.ca/drogues-illicites.asp)

Staatscourant. 1996. in Korf D.J. et H. Riper.1999. « Windmills in their Minds? Drug Policy and Drug Research in the Netherlands ». *Journal of Drug Issues* 29(3) : 451.

Statistique Canada. 1997. "Drogues illicites et criminalité au Canada". *Juristat.* Centre canadien de la statistique juridique. Catalogue N° 85-002-XIE.

Statistique Canada. 1999. "Dépenses de la justice au Canada", *Juristat.* Centre canadien de la statistique juridique. Catalogue N° 85-002-XIE.

Statistique Canada. 1999. "Drogues illicites et criminalité au Canada" *Juristat.* Centre canadien de la statistique juridique. Catalogue N° 85-002-XIE.

Statistique Canada. 2002. " Statistiques de la criminalité au Canada - 2001" *Juristat.* Centre canadien de la statistique juridique. Catalogue N° 85-002-XIE.

Stewart, David P. 1990. «Internationalizing The War on Drugs: The UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances ». *Denver Journal of International Law and Policy.* 18(3) : 387-404.

Stuart, D. 1999. "The Unfortunate Dilution of Section 8 Protection," *Queens Law Journal.* 25 (1).

Substance Abuse and Mental Health Services Administration. 2001. *Summary of findings from the 2000 national household survey on drug abuse.* Washington (D.C.) : Department of Health and Social Services.

Swift, W. et coll. 2001. «Cannabis use and dependence among Australian adults : Results from the National Survey of Mental Health and Wellbeeing ». *Addiction.* 96 : 737-748.

Sweden. 2000. *Summary of the report The Crossroads from the Swedish Commission of Narcotic Drugs.* Stockholm: The Swedish Commission on Narcotic Drugs.

Tashkin, D.P. et coll. 1997. « Heavy habitual marijuana smoking does not cause an accelerated decline in FEV1 with age : A longitudinal study». *American Journal of Respiratory Critical Care.* 155 : 141-148.

Taylor, A.C. 1969. *American Diplomacy and the Narcotics Traffic. 1900-1939: A Study in International Humanitarian Reform.* Durham (N.C.): Duke University Press

Taylor, Charles. 1998. *Les sources du moi : la formation de l'identité moderne.* Montréal : Boréal.

Taylor, F.M. 1988. « Marijuana as a potential respiratory tract carcinogen: A retrospective analysis of a community hospital population ». *Southern Medical Journal.* 81 : 1213-1216.

The Economist .2001. « Stumbling in the Dark ». 2001. *The Economist*, July 28 – August 3.

The Economist. 2001. « The Untouchables », *The Economist*, 21 avril 2001. 359 (8218) : 49

Trautmann, C. 1990. *Lutte contre la toxicomanie et le trafic de stupéfiants.* Rapport au premier ministre. Paris : La Documentation française.

Tribunal fédéral. *L'organisation judiciaire en Suisse*. (Disponible en ligne à l'adresse : http://www.bger.ch/index.cfm?language=french&area=Federal&theme=system&page=content&maskid=195)

Trimbos-Instituut. 2000. *The Netherlands Drug Situation 2000.* Report to the EMCDDA. Utrecht : Trimbost Instuut.(Disponible en ligne à l'adresse : www.emcdda.org)

United Nations .1976. *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.* Done at Vienna on 20 December 1988. New York : United Nations.

United Nations Office for Drug Control and Crime Prevention. 1998. *Country Drug Profile : Sweden.* 1998. Vienne : UNDCP.

United Nations Office for Drug Control and Crime Prevention. 2000. *Demand Reduction: A Glossary of Terms.* Vienne : UNDCP.

United Nations Office for Drug Control and Crime Prevention. 2001. *World Drug Report 2001.* Oxford : Oxford University Press.

United States. 1972. *International Narcotics Control: A Source Book of Conventions, Protocols, and Multilateral Agreements, 1909-1971.* Washington (D.C.) : Bureau of Narcotics & Dangerous Drugs.

Valois, Donat. 1972. «La marijuana et le haschisch ne seront pas légalisés ». *Le Droit*. Ottawa. 1er août 1972.

Van Laar, M., et coll. 2001. *Nationale Drug Monitor. Jaarbericht 2001.* Utrecht : NDM Bureau.

Van Ree, Erik. 1999. « Drugs as a Human Right ». *International Journal of Drug Policy*. 10 : 89-98

Vitaro, F., Gosselin C. et A. Girard. 2002. *Évolution de la consommation d'alcool et de drogues chez les jeunes au Québec de 1987 à 1998 : constatations, comparaisons et pistes d'explication.* Montréal : Comité permanent de lutte à la toxicomanie.

Wacquant, L. 2000. *Les prisons de la misère.* Paris : Éditions Raisons d'agir.

Walker III, William O. 1989. *Drug Control in the Americas.* Albuquerque (Nouveau-Mexique) : University of New Mexico Press. (édition révisée)

Walker III, William O. 1991. *Opium and Foreign Policy: The Anglo-American Search for Order in Asia, 1912-1954.* Chapel Hill (C. du N.) : University of North Carolina Press. p. 16-17, Lowes (1966) : 152-153.

Wasmeier, M., et coll. 2000. *Path analysis survey of substance use among Newfoundland and Labrador Adolescents. Marijuana / Haschich and Solvent use.* St John's : Memorial University of Newfoundland.

Wayne, H. et S. Wendy. 2000. « The THC content of cannabis in Australia : Evidence and implications.". *Australian and New Zealand Journal of Public Health.* 24 : 503-508.

Westlake, T.M. et coll. 1996. « Chronic exposure to delta-9-THC fails to irreversibly alter brain cannabinoid receptors. ». *Brain Research.* 544 : 145-149.

Wheelock, Barbara B. 2002. *Les impacts physiologiques et psychologiques du cannabis : une synthèse de la littérature.* Ottawa : Comité spécial du Sénat sur les drogues illicites.

Wiesbeck, G.A., et coll. 1996. « An evaluation of the history of a marijuana withdrawal syndrome in a large population. » *Addiction*, 91(10) : 1573-1579.

Wisotsky, S. 1990. *Beyond the War on Drugs: Overcoming a Failed Public Policy.* Buffalo : Prometheus Books.

Woody G.E. et coll. 1993. « Severity of dependence: Data from the DSM-IV field trials » *Addiction.* 88 : 1573-1579.

World Health Organization. 1997. *Cannabis : A Health Perspective and Research Agenda.* Geneva : WHO. (Disponible en ligne à l'adresse : www.who.org)

Zimmer L., et J.P. Morgan. 2000. *Marijuana. Mythes et réalités.* Paris : Georg. (2000 pour la version française ; 1997 pour l'original américain)

II - TÉMOIGNAGES CITÉS DANS LE RAPPORT

Mohamed ben Amar, professeur de pharmacologie et de toxicologie – Université de Montréal, Première session de la Trente-septième législature, 11 juin 2001, Fascicule N° 4.

Line Beauchesne, professeure de criminologie – Université d'Ottawa, Deuxième session de la Trente-sixième législature, 16 octobre 2000, Fascicule N° 1.

Patricia Bégin, directrice, Recherche et évaluation – Centre national de prévention du crime, Première session de la Trente-septième législature, 10 juin 2002, Fascicule N° 22.

Marie-Andrée Bertrand, professeure émérite de criminologie – Université de Montréal, Première session de la Trente-septième législature, 23 avril 2001, Fascicule N° 1.

Hilary Black, directrice du Club Compassion de Vancouver, Première session de la Trente-septième législature, 7 novembre 2001, Fascicule N° 10.

Tim Boekhout van Solinge, recherchiste en criminologie – Univeristé d'Utrecht, Première session de la Trente-septième législature, 19 novembre 2001, Fascicule N°. 11.

Micheal J. Boyd, président du Comité sur la toxicomanie et directeur adjoint de l'Association canadienne des Chefs de police, Première session de la Trente-septième législature, 11 mars 2002, Fascicule N° 14.

Neil Boyd, professeur de criminologie – Université Simon Fraser, Deuxième session de la Trente-sixième législature, 16 octobre 2000, Fascicule N° 1.

Serge Brochu, professeur – Université de Montréal et directeur du Centre international de criminologie comparée, Première session de la Trente-sixième législature, 10 décembre 2001, Fascicule N° 12.

Bill Campbell, président – Société médicale canadienne sur l'addiction, Première session de la Trente-septième législature, 11 mars 2002, Fascicule N° 14.

Mark Connolly, directeur général – Direction de la contrebande et des services de renseignements – Direction générale des douanes, Agence des douanes et du revenu du Canada, Première session de la Trente-septième législature, 29 octobre 2001, Fascicule N° 8.

John Conroy, avocat, Première session de la Trente-septième législature, 11 mars 2002, Fascicule N° 14.

Jean-Michel Coste, directeur de l'Observatoire français des drogues et des toxicomanies, Première session de la Trente-septième législature, 1er octobre 2001, Fascicule N° 7.

Patricia Erickson, recherchiste au Centre de toxicomanie et de santé mentale, Première session de la Trente-septième législature, 14 mai 2001, Fascicule N° 2.

Julian Fantino, chef du Service de police de Toronto, Première session de la Trente-septième législature, 10 septembre 2001, Fascicule N° 5.

Benedikt Fischer, professeur au Département des sciences de la santé publique – Université de Toronto, Première session de la Trente-septième législature, 17 septembre 2001, Fascicule N° 6.

David Griffin, Association canadienne des policiers et policières, Première session de la Trente-septième législature, 28 mai 2001, Fascicule N° 3.

Henry Haddad, président de l'Association médicale canadienne, Première session de la Trente-septième législature, 11 mars 2002, Fascicule N° 14.

Kash Heed, Services des drogues – Service de police de Vancouver, Première session de la Trente-septième législature, 7 novembre 2001, Fascicule N° 10

Gary E. Johnson, Gouverneur de l'État du Nouveau-Mexique, Première session de la Trente-septième législature, 5 novembre 2001, Fascicule N° 9.

Cal Johnston, chef du Service de police de Régina, Première session de la Trente-septième législature, 13 mai 2002, Fascicule N° 16.

Harold Kalant, professeur émérite – Université de Toronto, Première session de la Trente-septième législature, 11 juin 2001, Fascicule N° 4.

Perry Kendall, agent de santé de la province de la Colombie-Britannique, Première session de la Trente-septième législature, 17 septembre 2001, Fascicule N° 6.

Paul Kennedy, sous-solliciteur général adjoint principal – Secteur de la police et de la sécurité – Solliciteur général du Canada, Première session de la Trente-septième législature, 10 juin 2002, Fascicule N° 22.

Barry King, chef du Service de police de Brockville, Première session de la Trente-septième législature, 11 mars 2002, Fascicule N° 14.

R.G. Lesser, surintendant principal, Gendarmerie Royale du Canada, Première session de la Trente-septième législature, 29 octobre 2001, Fascicule N° 8.

Gillian Lynch, directrice générale, Stratégie antidrogue et substances contrôlées – Direction générale de la santé environnementale et de la sécurité des consommateurs, Santé Canada, Première session de la Trente-septième législature, 10 juin 2002, Fascicule N° 22.

Mary Lynch, directrice du Consortium canadien de recherche sur les cannabinoïdes, professeure – Université Dalhousie, Première session de la Trente-septième législature, 11 juin 2001, Fascicule N° 4.

Nicole Maestracci, présidente de la Mission interministérielle de lutte à la drogue et à la toxicomanie, Première session de la Trente-septième législature, 1er octobre 2001, Fascicule N° 7.

Colin Mangham, directeur de Prevention Source B.C., Première session de la Trente-septième législature, 17 septembre 2001, Fascicule N° 6.

Céline Mercier, professeure agrégée du département de psychiatrie – Université McGill, Première session de la Trente-septième législature, 10 décembre 2001, Fascicule N° 12.

Croft Michaelson, directeur et avocat général principal – Section de l'élaboration des politiques stratégiques en matière de poursuites, Justice Canada, Première session de la Trente-septième législature, 10 juin 2002, Fascicule N° 22.

John P. Morgan, professeur à la City University of New York Medical School, Première session de la Trente-septième législature, 11 juin 2001, Fascicule N° 4.

Dann Michols, sous-ministre adjoint – Direction générale de la santé environnementale et de la sécurité des consommateurs, Santé Canada, Première session de la Trente-septième législature, 10 juin 2002, Fascicule N° 22.

Dale Orban, Association canadienne des policiers et policières, Première session de la Trente-septième législature, 28 mai 2001, Fascicule N° 3.

Michel Perron, directeur exécutif du Centre canadien de lutte contre l'alcoolisme et les toxicomanies, Première session de la Trente-septième législature, 10 juin 2002, Fascicule N° 22.

Santé Canada, Première session de la Trente-septième législature, 10 juin 2002, Fascicule N° 22.

Sénat du Canada, délibérations du Comité spécial du Sénat sur les drogues illicites, Première session de la Trente-septième législature, mars-avril 2001, Fascicule N° 1.

Sénat du Canada, délibérations du Comité spécial du Sénat sur les drogues illicites, Première session de la Trente-septième législature, 28 mai 2001, Fascicule N° 3.

Eric Single, professeur, Département de la santé publique – Université de Toronto, Première session de la Trente-septième législature, 14 mai 2001, Fascicule N° 2..

Diane Steber Büchli, Office fédéral de la Santé publique de Suisse, Première session de la Trente-septième législature, 4 février 2002, Fascicule N° 13.

Art Steinman, directeur général – Alcohol-Drug Education Service, Première session de la Trente-septième législature, 7 novembre 2002, Fascicule N° 10.

Ambros Uchtenhagen, professeur – Institut de recherche sur les addictions, Première session de la Trente-septième législature, 4 février 2002, Fascicule N° 13.

Mark Ware, professeur adjoint de médecine familiale et d'anesthésie – Université McGill, Première session de la Trente-septième législature, 31 mai 2002, Fascicule N° 18

Mark Zoccolillo, professeur de psychiatrie et de pédiatrie – Université McGill, Deuxième session de la Trente-sixième législature, 16 octobre 2000, Fascicule N° 1.

VOLUME

VOLUME

4

Micromedia
ProQuest

20 Victoria Street
Toronto, Ontario M5C 2N8
Tel.: (416) 362-5211
Toll Free: 1-800-387-2689
Fax: (416) 362-6161
Email: info@micromedia.on.ca

Senate Sénat

CANADA

CANNABIS :

OUR POSITION FOR A CANADIAN PUBLIC POLICY

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

VOLUME IV : APPENDICES

CHAIRMAN

PIERRE CLAUDE NOLIN

DEPUTY CHAIRMAN

COLIN KENNY

SEPTEMBER 2002

APPENDIX I

MEMBERS AND STAFF OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

1. MEMBERS OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

Honourable Pierre Claude Nolin
(Chair)

Honourable Colin Kenny
(Deputy Chair)

Honourable Tommy Banks

Honourable Eileen Rossiter

Honourable Shirley Maheu

Honourable John Lynch-Staunton *

Honourable Sharon Carstairs, P.C.* **

Honourable Noël A. Kinsella *

Honourable Fernand Robichaud *

2. OTHER SENATORS WHO PARTICIPATED IN THE PROCEEDINGS OF THE COMMITTEE

Honourable Michel Biron

Honourable Laurier LaPierre

Honourable Pat Carney, P.C.

Honourable Jean Lapointe

Honourable Thelma Chalifoux

Honourable Edward M. Lawson

Honourable Ione Christensen

Honourable Lorna Milne

Honourable Ethel M. Cochrane

Honourable Yves Morin

Honourable Pierre De Bané, P.C., Q.C.

Honourable Lucie Pépin ***

Honourable Consiglio Di Nino

Honourable Marie-P. Poulin

Honourable Joyce Fairbairn, P.C.

Honourable Marcel Prud'homme, P.C.

Honourable Sheila Finestone, P.C.

Honourable Gerry St. Germain, P.C.

Honourable J. Michael Forrestall

Honourable Peter A. Stollery

Honourable Jerahmiel S. Grafstein, Q.C.

Honourable Terry Stratton

Honourable Mobina S.B. Jaffer

Honourable John Wiebe

Honourable Lois M. Wilson

* *Ex Officio* Members
** The Honourable Sharon Carstairs was a member of the Committee from April 2000 to October 2000
*** The Honourable Lucie Pépin was a member of the Committee from April 2000 to October 2000

3. STAFF OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

3.1 CLERKS

Blair Armitage
(Clerk)

Daniel Charbonneau
(Acting Clerk of the Committee)

Adam Thompson
(Acting Clerk of the Committee)

3.2 RESEARCH

Daniel Sansfaçon
(Director of Research)

Gérald Lafrenière
(Analyst – Library of Parliament)

Chantal Collin
(Analyst – Library of Parliament)

Lyne Casavant
(Library of Parliament)

Benjamin Dolin
(Library of Parliament)

Nancy Miller Chenier
(Library of Parliament)

François Dubois
(Office of Senator Pierre Claude Nolin)

Mollie Dunsmuir
(Library of Parliament)

Daniel Dupras
(Library of Parliament)

David Goetz
(Library of Parliament)

Anthony Jackson
(Library of Parliament)

Rebecca Jesseman
(Senate Special Committee on Illegal Drugs)

Diane Leduc
(Library of Parliament)

Martine Leroux
(Office of Senator Shirley Maheu)

Robin MacKay
(Library of Parliament)

Jeffrey Myers
(Senate Special Committee on Illegal Drugs)

Sonya Norris
(Library of Parliament)

Emmanuel Préville
(Library of Parliament)

Jay Sinha
(Library of Parliament)

Leah Spicer
(Library of Parliament)

Barbara B. Wheelock
(Office of Senator Eileen Rossiter)

3.3 ADMINISTRATION

Lise Bouchard
(Committees and Private Legislation Directorate of the Senate)

Keli Hogan
(Committees and Private Legislation Directorate of the Senate)

Nicole Bouchard
(Office of Senator Pierre Claude Nolin)

Mireille Khouri
(Committees and Private Legislation Directorate of the Senate)

Martine de Launière
(Special Committee on Illegal Drugs)

Nathalie Lemay-Paquette
(Committees and Private Legislation Directorate of the Senate)

Krista Durrell
(Committees and Private Legislation Directorate of the Senate)

Brigitte Martineau
(Committees and Private Legislation Directorate of the Senate)

Liliane Poiré
(Office of Senator Pierre Claude Nolin)

3.4 COMMUNICATIONS

Diane Boucher and her team
(Communications Directorate of the Senate)

Jean-Guy Desgagné
(Special Advisor – Senate Special Committee on Illegal Drugs)

David Newman
(Newman Communications)

3.5 REPORTERS, TRANSLATORS AND INTERPRETERS

Official Reporters of the Senate
(Debates and Publications Directorate of the Senate)

Translators
(Translation Bureau)

Interpreters
(Translation Bureau)

Thérèse Alier
(Private Text Editor)

APPENDIX II

LIST OF WITNESSES

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Cathy Airth	**Health Canada** Acting Director, Office of Canada's Drug Strategy, Health Environments and Consumer Safety Branch (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Bruce Alexander	**Simon Fraser University** Professor, Department of Psychology (Victoria, British Columbia)	**April 23, 2001** **Ottawa, Ontario**
Lindsay Armitage	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Lyell Armitage	**Regina Health District** Former Director, Alcohol and Drug Services (Regina, Saskatchewan) **Town Hall Panelist**	**May 13, 2002** **Regina, Saskatchewan**
Guy Ati Dion	**University of Montreal** (Montreal, Quebec)	**October 29, 2001** **Ottawa, Ontario**
George Bailey	**As an individual**	**May 14, 2002** **Richmond, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Linda Barnes	**City of Richmond** City Councillor (Richmond, British Columbia)	**May 14, 2002** **Richmond, British Columbia**
Pat Baumet	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
David Beall	**Inter-American Drug Abuse Control Commission** Executive Secretary (Washington (D.C.), United States of America)	**March 18, 2002** **Ottawa, Ontario**
Line Beauchesne	**University of Ottawa** Professor, Department of Criminology (Ottawa, Ontario)	**October 16, 2000** **Ottawa, Ontario**
Denise Beaudoin	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Patricia Bégin	**National Crime Prevention Centre** Director, Research and Evaluation (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Mohamed Ben Amar	**University of Montreal** Professor, Pharmacology and Toxicology (Montreal, Quebec)	**June 11, 2001** **Ottawa, Ontario**
Chris Bennett	**As an individual**	**November 7, 2001 and May 14, 2002** **Vancouver and Richmond, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Marie-Andrée Bertrand	**University of Montreal** Professor Emeritus of Criminology **Town Hall Panelist (Montreal)**	**April 23, 2001 and May 30, 2002** **Ottawa, Ontario** **Montreal, Quebec**
Beverly Best	**Village of Salisbury** City Councillor (Salisbury, New Brunswick)	**June 5, 2002** **Moncton, New Brunswick**
Hilary Black	**B.C. Compassion Club Society** Founder and Director (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**
Bill Blanchard	**Royal Canadian Mounted Police** Sergeant (Regina, Saskatchewan) **Town Hall Panelist**	**May 13, 2002** **Regina, Saskatchewan**
Guillaume Blouin-Beaudoin	**As an individual**	**May 30, 2002** **Montreal Quebec**
Ron Bocking	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Tim Boekhout Van Solinge	**Utrecht University** Lecturer and Researcher in Criminology (Utrecht, Netherlands)	**November 19, 2001** **Ottawa, Ontario**
Renee Boje	**As an individual**	**May 14, 2002** **Vancouver, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Stephen Bolton	**Department of Foreign affairs and International Trade** International Drug Officer, International Crime Division (Ottawa, Ontario)	**March 18, 2002** **Ottawa, Ontario**
Yvan Bombardier	**CACTUS** Intervener (Montreal, Quebec)	**May 30, 2002 and May 31st, 2002** **Montreal, Quebec**
Pierre-Charles Boudrias	**Dollard-Cormier Centre** (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**
David Bourgeois	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Michael J. Boyd	**Canadian Association of Chiefs of Police** Chair of the Drug Abuse Committee and Deputy Chief of the Toronto Police Service (Ottawa, Ontario)	**March 11, 2002** **Ottawa, Ontario**
Neil Boyd	**Simon Fraser University** Professor, Department of Criminology (Victoria, British Columbia)	**October 16, 2000** **Ottawa, Ontario**
Al Breau	**Village of Salisbury** Member of the Salisbury Municipal Drug Strategy (Salisbury, Nouveau-Brunswick) **Town Hall Panelist**	**June 5, 2002** **Moncton, New Brunswick**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Serge Brochu	**University of Montreal** Professor and Director of the International Center for Comparative Criminology (Montreal, Quebec)	**December 10, 2001** **Ottawa, Ontario**
Nick Brusatore	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Perry Bulwer	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Fred Burford	**As an individual**	**September 10** **Toronto, Ontario**
Michele Burque	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Tracy Butler	**Salvation Army Harbour Light Addiction and Rehabilitation Treatment Centre, HCC St. John's** Program Director (St. John's, Newfoundland and Labrador)	**June 4, 2002** **St-John's, Newfoundland and Labrador**
Bill Campbell	**Canadian Society on Addiction Medicine** President (Ottawa, Ontario)	**March 11, 2002** **Ottawa, Ontario**
Chris Carnell	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Nicolas Carrier	**As an individual**	**May 30, 2002** **Montreal, Quebec**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
James Anthony Cavalier	**As an individual**	**September 10** **Toronto, Ontario**
Walter Cavalieri	**Toronto Harm Reduction Task Force** (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**
Jean-Pierre Chiasson	**Clinique du Nouveau Départ Inc.** Medical Director (Montreal, Quebec) **Town Hall Panelist**	**May 30, 2002** **Montreal, Quebec**
Ward Clapham	**Royal Canadian Mounted Police** Superintendent (Richmond, British Columbia)	**May 14, 2002** **Richmond, British Columbia**
Chantal Cloutier-Vautour	**Addiction Services, Health Region** Addiction Councillor (Moncton, New Brunswick)	**June 5, 2002** **Moncton, New Brunswick**
Pierre Cloutier	**As an individual**	**May 31, 2002** **Montreal, Quebec**
Peter Cohen	**University of Amsterdam** Professor (Amsterdam, Netherlands)	**May 28, 2001** **Ottawa, Ontario**
Émile Colas	**As an individual** **Town Hall Panelist**	**May 30, 2002** **Montreal, Quebec**
Mark Connolly	**Canada Customs and Revenue Agency** Director General, Contraband and Intelligence Services Directorate, Customs Branch (Ottawa, Ontario)	**October 29, 2001** **Ottawa, Ontario**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
John W. Conroy	**As an individual** Barrister and Solicitor in *(R. v. Malmo-Levine and R. v. Caine)*	**March 11, 2002** **Ottawa, Ontario**
Randy Cormier	**Brentwood Recovery Home** Counsellor/Group Leader (Windsor, Ontario)	**June 7, 2002** **Windsor, Ontario**
Terry Cormier	**Department of Foreign affairs and International Trade** Director, International Crime Division (Ottawa, Ontario)	**March 18, 2002** **Ottawa, Ontario**
Jean-Michel Coste	**French Monitoring Centre for Drugs and Drug Addictions** Director (Paris, France)	**October 1st, 2001** **Ottawa, Ontario**
Roland Côté	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Richard Cowan	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Michael Crichton	**Canada Customs and Revenue Agency** Chief, Intelligence and Operations Division, Contraband and Intelligence Services Directorate, Customs Branch (Ottawa, Ontario)	**October 29, 2001** **Ottawa, Ontario**
Jean de Lavaltrie	**As an individual**	**May 30, 2002** **Montreal, Quebec**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
France Desjardins	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Chuck Doucette	**Royal Canadian Mounted Police** (Vancouver, British Columbia) **Town Hall Panelist**	**May 14, 2002** **Richmond, British Columbia**
Wally Dowhayko	**Royal Canadian Mounted Police** Sergeant, Windsor Drug Section (Windsor, Ontario)	**June 7, 2002** **Windsor, Ontario**
Caroline Doyer	**Club Compassion de Montréal** President (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**
Toby Druce	**Seaton House** Program Supervisor (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**
Françoise Dubois-Arber	**Swiss Federal Commission for Drug Issues; University Institute for Social and Preventative Medicine** Member (Bern, Switzerland)	**February 4, 2002** **Ottawa, Ontario**
Georges Dulex	**Canton of Zurich, Criminal Police Department** Head (Zurich, Switzerland)	**February 4, 2002** **Ottawa, Ontario**
Johnny Dupuis	**As an individual**	**May 30, 2002** **Montreal, Quebec**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Martin Earl	**As an individual**	**June 6, 2002** **Windsor, Ontario**
Bill Elliot	**Canada Customs and Revenue Agency** Director, Windsor-St. Clair District (Windsor, Ontario)	**June 7, 2002** **Windsor, Ontario**
Marc Emery	**B.C. Marijuana Party** (Vancouver, British Columbia) **Town Hall Panelist**	**May 14, 2002** **Richmond, British Columbia**
Ron Enns	**As an individual**	**June 6, 2002** **Windsor, Ontario**
Patricia Erickson	**Centre for Addiction and Mental Health** Researcher (Toronto, Ontario)	**May 14, 2001** **Ottawa, Ontario**
Julian Fantino	**Toronto Police Service** Chief (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**
Pat Fiacco	**City of Regina** Mayor (Regina, Saskatchewan)	**May 13, 2002** **Regina, Saskatchewan**
Ross Findlater	**Regina Health District** Deputy Medical Health Officer, Alcohol and Drug Services (Regina, Saskatchewan)	**May 13, 2002** **Regina, Saskatchewan**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Benedikt Fischer	**University of Toronto** Professor, Department of Public Health Sciences (Toronto, Ontario)	**September 17, 2001** **Ottawa, Ontario**
Jerry Fitzgerald	**Alcohol and Drug Services, Regina Health District** Manager (Regina, Saskatchewan)	**May 13, 2002** **Regina, Saskatchewan**
Donald Fitzsimmons	**Alcohol and Drug Services, Regina Health District** Youth and Family Coordinator (Regina, Saskatchewan)	**May 13, 2002** **Regina, Saskatchewan**
Mark Fortier	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Michel Frenette	**Royal Canadian Mounted Police** Drug Awareness Services Coordinator (Fredericton, New Brunswick) **Town Hall Panelist**	**June 5, 2002** **Moncton, New Brunswick**
Thomas Fulgosi	**Seaton House** Shift Leader (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**
Nick Gallant	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
Paul E. Garfinkel	**Centre for Addiction and Mental Health** President and C.E.O. (Toronto, Ontario)	**June 7, 2002** **Windsor, Ontario**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Serge Gascon	**City of Montreal Police Service** Deputy Director (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**
Ryan Genie	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Michel Germain	**Comité permanent de lutte à la toxicomanie** Director General (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**
Rob Gillespie	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
John P. Gordon	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Hélène Goulet	**Health Canada** Director General, Tobacco Control Programme, Health Environments and Consumer Safety Branch (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Caylie Graham	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Serge Granger	**University of Quebec in Montreal** Historian (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**
Brian Grant	**Correctional Service Canada** Director, Addictions Research Centre (Montague, Prince Edouard Island)	**June 10, 2002** **Ottawa, Ontario**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
David Griffin	**Canadian Police Association** Executive Officer (Ottawa, Ontario)	**May 28, 2001** **Ottawa, Ontario**
Peter Grin	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Derril W. Gudlaugson	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
André-Bernard Guévin	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Cathleen Guthrie	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Henry Haddad	**Canadian Medical Association** President (Ottawa, Ontario)	**March 11, 2002** **Ottawa, Ontario**
Susan Hague	**Canada Customs and Revenue Agency** Senior Program Advisor, Contraband Operations Section, Contraband and Intelligence Services Directorate, Customs Branch (Ottawa, Ontario)	**October 29, 2001** **Ottawa, Ontario**
Nichola Hall	**Grief to Action** Chairperson (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**
Ross Hall	**Grief to Action**	**November 7, 2001** **Vancouver, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Peter Hamel	**Club Compassion de Montréal** Executive Director (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**
Tony Hammer	**As an individual**	**June 6, 2002** **Windsor, Ontario**
Timothy Hampton	**NORML Saskatchewan** President, National Organization for Reform of Marijuana Laws (NORML) (Watrous, Saskatchewan) **Town Hall Panelist**	**May 13, 2002** **Regina, Saskatchewan**
Michael C. Hansen	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Andy Hathaway	**Centre for Addiction and Mental Health** Researcher (Toronto, Ontario)	**May 14, 2001** **Ottawa, Ontario**
Glen Hayden	**Canadian Police Association** Detective, Drug Control Section, Edmonton Police Service (Ottawa, Ontario)	**May 28, 2001** **Ottawa, Ontario**
Kenneth E. Hayes Jr.	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Kash Heed	**Vancouver Police Service** Drugs Section (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Sean Hunt	**As an individual**	**September 10, 2001** **Toronto, Ontario**
Thomas E. Hunter	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
Alexis Jabarit	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Edward Jackson	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Gary E. Johnson	**State of New Mexico** Governor (Albuquerque, New Mexico – United States of America)	**November 5, 2001** **Ottawa, Ontario**
Cal Johnston	**Regina Police Service** Chief of Police (Regina, Saskatchewan)	**May 13, 2002** **Regina, Saskatchewan**
Hélène Jutras	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Harold Kalant	**University of Toronto** Professor Emeritus (Toronto, Ontario)	**June 11, 2001** **Ottawa, Ontario**
Sean Karl	**As an individual**	**May 14, 2002** **Richmond, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Robert Keizer	**Ministry of Health, Welfare and Sports of the Netherlands** Drug Policy Advisor (The Hague, Netherlands)	**November 19, 2001** **Ottawa, Ontario**
Jim Kelly	**Richmond Alcohol and Drug Action Team (RADAT)** Director (Richmond, British Colombia)	**May 14, 2002** **Richmond, British Columbia**
Perry Kendall	**As an individual** Health Officer (Victoria, British Columbia)	**September 17, 2001** **Ottawa, Ontario**
Paul E. Kennedy	**Solicitor General of Canada** Senior Assistant Deputy Solicitor General, Policing and Security Branch (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Steven Kent	**City of Mount Pearl** Deputy Mayor (Mount Pearl, Newfoundland and Labrador)	**June 4, 2002** **Mount Pearl, Newfoundland and Labrador**
Barry King	**Canadian Association of Chiefs of Police** Former Chair of the Drug Abuse Committee and Chief of the Brockville Police Service (Ottawa, Ontario)	**March 11, 2002** **Ottawa, Ontario**
Michel Kokoreff	**Lille University** (Lille, France)	**October 1st, 2001** **Ottawa, Ontario**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Dirk J. Korf	**University of Amsterdam** Professor (Amsterdam, Netherlands)	**November 19, 2001** **Ottawa, Ontario**
Michele Kubby	**As an individual**	**May 14, 2002** **Richmond, British Colombia**
Alain Labrousse	**Observatoire français des drogues et des toxicomanies** Chargé de mission (Paris, France)	**May 28, 2001** **Ottawa, Ontario**
C. Gwendolyn Landolt	**REAL Women of Canada** National Vice-President (Ottawa, Ontario) **Town Hall Panelist**	**June 6, 2002 and June 7, 2002** **Windsor, Ontario**
Michel Landry	**Dollard-Cormier Centre** Director of Professional Services and Research (Montreal, Quebec)	**December 10, 2001** **Ottawa, Ontario**
Julie Langlois	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Dana Larsen	**Cannabis Culture** (Vancouver, British Columbia) **Town Hall Panelist**	**November 7, 2001 and May 14, 2002** **Vancouver and Richmond, British Columbia**
Pierre Lauzon	**As an individual** **Town Hall Panelist**	**May 30, 2002** **Montreal, Quebec**
Marc-André Lavoie	**As an individual**	**May 30, 2002** **Montreal, Quebec**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
James Leslie	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Robert G. Lesser	**Royal Canadian Mounted Police** Chief Superintendent (Ottawa, Ontario) **Canadian Association of Chiefs of Police** Vice Chair of the Drug Abuse Committee (Ottawa, Ontario)	**October 29, 2001 and March 11, 2002** **Ottawa, Ontario**
Mason Loh	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Dennis Long	**Breakaway** Executive Director (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**
Blair T. Longley	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Cynthia Low	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Phillippe Lucas	**Vancouver Island Compassion Society** Director (Victoria, British Columbia)	**May 14, 2002** **Richmond, British Columbia**
Gillian Lynch	**Health Canada** Director General, Drug Strategy and Controlled Substances Programme (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Mary Lynch	**Dalhousie University** Director, Canadian Consortium for the Investigation of Cannabinoids (Halifax, Nova Scotia)	**June 11, 2001** **Ottawa, Ontario**
Sandy MacDonald	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Edward J. MacEachern	**Royal Canadian Mounted Police** Sergeant (Fredericton, New Brunswick)	**June 5, 2002** **Moncton, New Brunswick**
David MacFarnam	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Chris MacLean	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
Donald MacPherson	**City of Vancouver** Drug Policy Coordinator (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**
Nicole Maestracci	**Interministerial Mission for the Fight against Drugs and Drug Addiction** President (Paris, France)	**October 1st, 2001** **Ottawa, Ontario**
Achille Maillet	**Addiction Services, Health Region** Director (Moncton, New Brunswick)	**June 5, 2002** **Moncton, New Brunswick**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
David Malmo-Levine	**As an individual**	**November 7, 2001 and May 14, 2002** **Vancouver and Richmond, British Columbia**
Colin R. Mangham	**Prevention Source B.C.** Director (Vancouver, British Columbia)	**September 17, 2001** **Ottawa, Ontario**
Bill Marra	**Federation of Canadian Municipalities** Chair of the Standing Committee on Community Safety and Crime Prevention and City Councillor for the City of Windsor (Ottawa, Ontario)	**March 11, 2002** **Ottawa, Ontario**
Richard Mathias	**University of British Columbia** Professor, Health Care and Epidemiology Department (Vancouver, British Colombia)	**September 17, 2001** **Ottawa, Ontario**
Pierre Matteau	**As an individual**	**May 30, 2002** **Montreal, Quebec**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
William B. McAllister	**University of Virginia** Professor (Charlottesville, Virginia, United States of America)	**March 18, 2002** **Ottawa, Ontario**
Michael McCoy	Touchtone Family Association (Richmond, British Columbia) **Town Hall Panelist**	**May 14, 2002** **Richmond, British Colombia**
John McIntyre	**BC Civil Liberties Association** Member of the Board (Vancouver, British Columbia)	**May 14, 2002** **Richmond, British Columbia**
W. Joe McKeown	**City of Regina** City Councillor **(Regina, Saskatchewan)** **Town Hall Panelist**	**May 13, 2002** **Regina, Saskatchewan**
William A. McKim	**Memorial University of Newfoundland** Acting Head, Department of Psychology (Mount Pearl, Newfoundland and Labrador) **Town Hall Panelist**	**June 3, 2002** **Mount Pearl, Newfoundland and Labrador**
Ken McLennan	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Wanda McPherson	**Springboard** Diversion Coordinator (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Timothy Meehan	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Céline Mercier	**McGill University** Associate Professor, Department of Psychiatry (Montreal, Quebec)	**December 10, 2001** **Ottawa, Ontario**
Croft Michaelson	**Justice Canada** Director and Senior General Counsel, Strategic Prosecution Policy Section (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Dann Michols	**Health Canada** Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Mike Moldovan	**As an individual**	**June 6, 2002** **Windsor, Ontario**
John P. Morgan	**City of New York Medical School** Professor of Pharmacology (City of New York, New York, United States of America)	**June 11, 2001** **Windsor, Ontario**
Tracy Mortensen	**As an individual**	**June 6, 2002** **Windsor, Ontario**
David Mossop	**Community Legal Assistance Society** (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Ethan Nadelman	**Lindesmith Centre** Executive Director (City of New York, New York, United States of America)	**November 5, 2001** **Ottawa, Ontario**
Janet Neves	**Federation of Canadian Municipalities** Policy Analyst (Ottawa, Ontario)	**March 11, 2002** **Ottawa, Ontario**
John Noddin	**New Brunswick Home and Schools Association** Former President **Town Hall Panelist**	**June 5, 2002** **Moncton, New Brunswick**
Kathryn Noddin	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
Dale Orban	**Canadian Police Association** Sergeant and Detective, Regina Police Service Executive Director, Regina Police Association (Ottawa, Canada)	**May 28, 2001** **Ottawa, Ontario**
Albert G. Ormiston	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Eugene Oscapella	**Canadian Foundation for Drug Policy** Executive Director (Ottawa, Ontario)	**October 16, 2000 and October 29, 2001** **Ottawa, Ontario**
Philip Owen	**City of Vancouver** Mayor (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Melanie Stephen Patriquen	**Marijuana Party of Canada** (Montreal, Quebec)	**June 5, 2002** **Moncton, New Brunswick**
Mike Patriquen	**Marijuana Party of Canada** (Montreal, Quebec) **Town Hall Panelist**	**June 5, 2002** **Moncton, New Brunswick**
Caroline Pelchat	**Royal Canadian Mounted Police** Researcher, Drug Awareness Service (Ottawa, Ontario)	**October 29, 2001** **Ottawa, Ontario**
Michel Pelletier	**Royal Canadian Mounted Police** Sergeant and National Coordinator, Drug Awareness Service (Ottawa, Ontario)	**October 29, 2001** **Ottawa, Ontario**
Michel Perron	**Canadian Centre on Substance Abuse** Executive Director (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Martin Petit	**CACTUS** Community Worker (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Robert Pike	**Penitentiary Addictions Group** Classification Officer (St. John's, Newfoundland and Labrador)	**June 4, 2002** **Mount Pearl, Newfoundland and Labrador**
Jim Power	**Royal Canadian Mounted Police** Sergeant (Clarenville, Newfoundland and Labrador) **Town Hall Panelist**	**June 3, 2002** **Mount Pearl, Newfoundland and Labrador**
Diane Power-Jeans	**Janeway Community Mental Health Division, HCC St. John's** Social Worker (St. John's, Newfoundland and Labrador)	**June 4, 2002** **Mount Pearl, Newfoundland and Labrador**
Fred Pritchard	**Marijuana Compassion Club of Windsor** Founder and Operator **(Windsor, Ontario)** **Town Hall Panelist**	**June 6, 2002** **Windsor, Ontario**
Norman Qworden	**As an individual**	**June 6, 2002** **Windsor, Ontario**
Alan Randell	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Eleanor Randell	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Shauna Raycraft	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Jürgen Rehm	**University of Zurich** Professor (Zurich, Switzerland)	**May 14, 2001** **Ottawa, Ontario**
Rick Reimer	**As an individual**	**May 31, 2002** **Montreal, Quebec**
Dave Roberts	**Windsor Police Service** Inspector, Investigation Services (Windsor, Ontario)	**June 7, 2002** **Windsor, Ontario**
Gerald Royce	**As an individual**	**June 3, 2002** **Mount Pearl, Newfoundland and Labrador**
Jerome Sabourin	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
Greg Schweitzer	**As an individual**	**June 6, 2002** **Windsor, Ontario**
Darlene Simpson	**House of Sophrosyne** Director of Program (Windsor, Ontario)	**June 7, 2002** **Windsor, Ontario**
Eric Single	**University of Toronto** Professor, Department of Public Health Sciences (Toronto, Ontario)	**May 14, 2001** **Ottawa, Ontario**
Leon Smith	**As an individual**	**May 14, 2002** **Richmond, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Patrick Smith	**Centre for Addiction and Mental Health** Vice-President, Clinical Programs (Toronto, Ontario)	**June 7, 2002** **Windsor, Ontario**
Ted Smith	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Raf Souccar	**Royal Canadian Mounted Police** Superintendent (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Rob Spring	**As an individual**	**June 6, 2002** **Windsor, Ontario**
Randall St. Jacques	**As an individual**	**June 6, 2002** **Windsor, Ontario**
Margaret Stanowski	**Springboard** Executive Director (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**
Paul St-Denis	**Justice Canada** Senior Counsel, Criminal Law Policy Section (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Diane Steber Büchli	**Swiss Federal Office of Public Health** Head, International Drug Affairs Unit (Bern, Switzerland)	**February 4, 2002** **Ottawa, Canada**
Art Steinmann	**Alcohol-Drug Education Service** Executive Director (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Marc-Boris St-Maurice	**Marijuana Party** Leader (Montreal, Quebec) **Town Hall Panelist**	**May 30, 2002 and May 31st** **Montreal, Quebec**
Ron Taverner	**Toronto Police Service** Sergeant, Superintendent (Toronto, Ontario)	**June 7, 2002** **Windsor, Ontario**
Rosaire Théorêt	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Rick Tipple	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Lilian To	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Ross Toller	**Correctional Service Canada** Deputy Commissioner, Prairie Region (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Chris Trenholm	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
John Turmel	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Ray Turmel	**As an individual**	**May 30, 2002** **Montreal, Quebec**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Selene Tracy Tyndale	**Ontario Public Interest Research Group** Volunteer (Windsor, Ontario) **Town Hall Panelist**	**June 6, 2002** **Windsor, Ontario**
Mark Tyndall	**B.C. Centre for Excellence in HIV/AIDS** (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**
Ambros Uchtenhagen	**Addiction Research Institute** Retired Professor (Zurich, Suisse)	**February 4, 2002** **Ottawa, Ontario**
Steven Van Hoogstraten	**Ministry of Justice of the Netherlands** Director for International Criminal Affairs and Drugs Policy (The Hague, Netherlands)	**November 19, 2001** **Ottawa, Ontario**
Anne Vogel	**Gilwest Clinic** Manager (Richmond, British Columbia)	**May 14, 2002** **Richmond, British Columbia**
John Walsh	**City of Mount Pearl** City Councillor (Mount Pearl, Newfoundland and Labrador) **Town Hall Panelist**	**June 3, 2002** **Mount Pearl, Newfoundland and Labrador**
Chuck Walter	**Royal Canadian Mounted Police** Officer in Charge, Operational Systems Policy Section, National Contract Policing Branch (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Thia Walter	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Mark A. Ware	**McGill University** Assistant Professor (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**
David Weinberg	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
Yves Wermelinger	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
Anna Marie White	**Focus on the Family** Policy Analyst (Vancouver, British Columbia)	**May 14, 2002** **Richmond, British Columbia**
Dean Wilson	**Vancouver Area Network of Drug Users (VANDU)** Executive Director (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**
Cory Wint	**Inner Visions Recovery Society** (Vancouver, British Columbia) **Town Hall Panelist**	**May 14, 2002** **Richmond, British Columbia**
Brad Wolbaum	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Scott Wolbaum	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Danny Woods	**Windsor Police Service** Sergeant, Drug Enforcement Branch (Windsor, Ontario)	**June 7, 2002**
Alan Young	**As an individual** Associate Professor, Osgoode Hall Law School (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**
Mark Zoccolillo	**McGill University** Professor, Department of Psychiatry (Montreal, Quebec)	**October 16, 2000** **Ottawa, Canada**

APPENDIX III

RESEARCH PAPERS *

A- RESEARCH PAPERS PREPARED BY THE PARLIAMENTARY RESEARCH BRANCH OF THE LIBRARY OF PARLIAMENT

AUTHORS	TITLE	DATE OF PUBLICATION
Lyne Casavant, Chantal Collin	**Illegal Drug Use and Crime : A Complex Relationship**	August 2001
Chantal Collin	**National Drug Policy: France**	August 2001
Chantal Collin	**National Drug Policy: Switzerland**	January 2002
Benjamin Dolin	**National Drug Policy: United States of America**	July 2001
Benjamin Dolin	**National Drug Policy: Netherlands**	August 2001
Daniel Dupras	**Canada's International Obligations Under the Leading International Conventions on the Control of Narcotics Drugs**	October 1998
David Goetz	**Drug Prohibition and the Constitution**	March 2001
Anthony Jackson	**The Costs of Drug Abuse and Drug Policy**	April 2002
Diane Leduc, Nancy Miller Chenier, Sonya Norris	**Inventory of Federal Research on Illegal Drugs and Related Issues**	October 2001

* All the research papers quoted in this appendix were produced at the request of the Senate Special Committee on Illegal Drugs and are available at: www.parl.gc.ca/illegal-drugs.asp

AUTHORS	TITLE	DATE OF PUBLICATION
Diane Leduc, Nancy Miller Chenier, Sonya Norris	**Inventory of Provincial and Territorial Research on Illegal Drugs and Related Issues**	May 2002
Gérald Lafrenière	**Police Powers and Drug-Related Offences**	March 2001
Gérald Lafrenière	**National Drug Policy: United Kingdom**	July 2001
Gérald Lafrenière	**National Drug Policy: Sweden**	April 2002
Gérald Lafrenière, Emmanuel Préville	**Reported Incidents, Convictions, Incarceration and Sentencing in Relation to Illegal Drugs in Canada**	May 2002
Gérald Lafrenière, Leah Spicer	**Illicit Drug Trends in Canada 1980-2001: A Review and Analysis of Enforcement Data**	June 2002
Robin MacKay	**National Drug Policy: Australia**	December 2001
Jay Sinha	**The History and Development of the Leading International Drug Control Conventions**	February 2001
Leah Spicer	**Historical and Cultural Uses of Cannabis and the Canadian "Marijuana Clash"**	April 2002

B- RESEARCH PAPERS ON GUIDING PRINCIPLES

AUTHORS	TITLE	DATE OF PUBLICATION
Thomas De Koninck **Laval University**	**The Role of Knowledge and Culture in Public Policy on Illegal Drugs**	June 2002
Roderick A. Macdonald **McGill University**	**The Governance of Human Agency**	May 2001
Jean-François Malherbe **University of Sherbrooke**	**The Contribution of Ethics in Defining Guiding Principles for a Public Drug Policy**	May 2002
Alvaro P. Pires **University of Ottawa**	**La politique législative et les crimes à « double face » : Éléments pour une théorie pluridimensionnelle de la loi criminelle**	June 2002

C- OTHER RESEARCH PAPERS

AUTHORS	TITLE	DATE OF PUBLICATION
François Dubois **Office of Senator Pierre Claude Nolin**	**The Federal Parliament and the Evolution of Canadian Legislation on Illegal Drugs**	June 2002
Léger Marketing **Montreal**	**An Exploratory Study Among Canadians About the Use of Cannabis**	June 2002
Diane Riley **University of Toronto**	**Drugs and Drug Control Policy: A Brief Review and Commentary**	November 1998
Barbara B. Wheelock **Office of Senator Eileen Rossiter**	**Physiological and Psychological Effects of Cannabis: Review of the Research Findings**	May 2002

APPENDIX IV

The Evolution of Canadian Drug Legislation (1908-1996): Offences, Penalties, Police Powers and Criminal Procedure*

Act	Offences	Penalties	Police Powers – Criminal Procedure
1908 –	*Trafficking*		
Opium Act	• **Importation for non-medical purposes and without the authorization of the Minister of Customs** • **Manufacture, sale or <u>possession, for the purpose of selling</u>, of raw or prepared opium** • **Manufacture, sale or <u>possession, for the purpose of selling</u>, opium prepared for the use of smokers**	**Indictment** • **Imprisonment for a term not exceeding 3 years; and / or** • **Fine of not less than $50 and not exceeding $1,000**	

*This chart is taken from the study prepared by François Dubois entitled *The Federal Parliament and the Evolution of Canadian Legislation on Illegal Drugs*. The study is available online at: www.parl.gc.ca/illegal-drugs.asp

Act	Offences	Penalties	Police Powers – Criminal Procedure
1911 – **Opium and Narcotic Drug Act**	*Trafficking* • **Importation, transportation within Canada, manufacture, sale or offering for sale, <u>without lawful excuse</u>, of a drug for non-therapeutic or non-scientific purposes**	**Summary conviction** • **Imprisonment for a term not exceeding one year; and / or** • **Fine not exceeding $500**	*Police powers* **Search warrants** • **Search warrant authorizing, on reasonable grounds:** ▪ **the search of the following places: dwelling houses, stores, boutiques, warehouses, gardens or ships; and** ▪ **the seizure of any drugs found there and of the containers in which they are found**
	• **Exportation, <u>without lawful excuse</u>, to a country that prohibits the importing of a drug**	**Summary conviction** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $500**	*Criminal procedure* **Destruction of seized drugs** • **Order allowing the destruction of drugs and containers in which they were found after conviction of the accused**
	Possession • **Possession of a drug, <u>without lawful excuse</u>, for non-therapeutic or non-scientific purposes**	**Summary conviction** • **Imprisonment for a term not exceeding one year; and / or** • **Fine not exceeding $500**	• **Order providing for the return of seized drugs if the accused is acquitted. If not claimed, they have to be destroyed within three months following the acquittal**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• **Possession of opium prepared for smokers or its use**	**Summary conviction** • **Imprisonment for a term not exceeding 3 months; and / or** • **Fine not exceeding $50**	**Reverse onus** • **In a prosecution for trafficking or possession of drugs, the accused has to prove:** ▪ **the existence of a lawful excuse; or** ▪ **that the substances were used for therapeutic or scientific purposes**
	• **Being found, without lawful <u>excuse</u>, in a place where opium is smoked**	**Summary conviction** • **Imprisonment for a term not exceeding one month; and / or** • **Fine not exceeding $100**	**Writ of *certiorari*** • **Elimination of use of a writ of *certiorari***
	Legal trade in narcotic drugs **(Physicians)**		**Reward**
	• **Prescription of drugs for non-medical purposes particularly if they are not required for the treatment of illness**	**Summary conviction** • **Imprisonment for a term not exceeding 3 months; and / or** • **Fine not exceeding $200**	• **Possibility to use a portion of a fine paid by an offender to reward the person who filed the complaint against him**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	(Pharmacists)		
	• **Sale of drugs for medical purposes without prescription (in writing or by telephone) by a physician**	**Summary conviction** • **Imprisonment for a term not exceeding 3 months; and / or** • **Fine not exceeding $200**	
	• **Refusal to keep a record of drug purchases and sales, the making of medications containing such substances and the renewal of prescriptions issued by a physician**	**Summary conviction** • **Imprisonment for a term not exceeding 3 months; and / or** • **Fine not exceeding $200**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1920 –	*Trafficking*		
Amendments to Act of 1911	• Exportation or importation, manufacture, transportation within Canada, sale and distribution of a drug without a license, or its importation at a port not designated by federal authorities	Summary conviction • Imprisonment for a term not exceeding one year; and / or • Fine of not less than $200 and not exceeding $1,000	
	• Exportation or importation, manufacture, transporting within Canada, sale and distribution of raw or prepared opium without a license		
	Possession		
	• Possession of drugs, without a license, for non-medical or non-scientific purposes	Summary conviction • Imprisonment for a term not exceeding one year; and / or • Fine of not less than $200 and not exceeding $1,000	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Legal Trade in narcotic drugs		
	(Businesses)		
	• **Refusal to keep a record of activities, duly authorized by federal authorities, relating to the importing, exporting, manufacture, sale and distribution of drugs**	**Summary conviction** • **Imprisonment for a term not exceeding one year; and / or** • **Fine of not less than $200 and not exceeding $1,000**	
	(Physicians)		
	• **Refusal to provide information requested by federal authorities relating to the purchase, preparation or prescription of medications containing drugs**	**Summary conviction** • **Imprisonment for a term not exceeding one year; and / or** • **Fine of not less than $200 and not exceeding $1,000**	
	(Pharmacists)		
	• **Sale of drugs for medical purposes <u>without a prescription written and signed</u> by a physician**	**Summary conviction** • **Imprisonment for a term not exceeding one year; and / or** • **Fine of not less than $500 and not exceeding $1,000**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• **Sale or administration of a product containing quantities of drugs exceeding the limits prescribed by the Act and without appropriate labelling to a child under 2 years of age**	**Summary conviction** • **Imprisonment for a term not exceeding one year; and / or** • **Fine of not less than $200 and not exceeding $1,000**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1921 – **Amendments to Act of 1911**	*Trafficking* • Illegal activities as defined in the Act of 1920	Indictment • Imprisonment for a term not exceeding 7 years Summary conviction • Imprisonment for a term not exceeding 18 months, to which may be added an additional period of 12 months for failure to pay a fine; and / or • Fine of not less than $200 and not exceeding $1,000	*Criminal procedure* Forfeiture or return of seized drugs • Order providing for the forfeiture to the Minister of Health of seized drugs and the receptacles in which they were found following conviction of the accused • Order providing for the return of seized drugs if the accused was acquitted. If not claimed, they were forfeited to the Minister of Health, not later than two months following the acquittal, for disposal by the minister as he saw fit
	• Selling, giving or distributing drugs to a minor without a license	Indictment • Imprisonment for a term not exceeding 7 years	Reverse onus • Every person possessing or occupying a place (dwelling, store, boutique, warehouse, garden or ship) where a drug is found is deemed to possess such a substance where unable to prove that he: ▪ was in that place without his consent; or ▪ did not know that drugs were in that place.

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Possession • Possession	**Indictment** • **Imprisonment for a term not exceeding 7 years** **Summary conviction** • **Imprisonment for a term not exceeding 18 months, to which may be added an additional period of 12 months for failure to pay a fine; and / or** • **Fine of not less than $200 and not exceeding $1,000**	**Where a person is charged with exporting, importing, making, transporting, selling, giving or distributing raw or prepared opium without first having obtained a license issued by federal authorities, he shall prove that he held such authorization.** **Certificate of a federal analyst** • **Admissibility in evidence of a certificate of a federal analyst respecting one or more drugs seized by police officers**

Act	Offences	Penalties	Police Powers – Criminal Procedure
1922 – **Amendments to Act of 1911**	*Trafficking* • Illegal activities as defined in the Act of 1920, <u>with the exception of most offences involving raw or prepared opium without a license</u> • <u>Continuation of the offence regarding the exportation of raw or prepared opium</u>	Indictment • Imprisonment for a term not exceeding 7 years Summary conviction • Imprisonment for a term of not less than 6 months and not exceeding 18 months; and • Fine of not less than $200 and not exceeding $1,000 (Deportation of immigrants upon completion of sentence)	*Police powers* Search warrants • Authorization to conduct a search and seizure of drugs, <u>without a warrant,</u> in the following places: stores, boutiques, warehouses, gardens and ships • Authorization to to search a dwelling house, with a warrant, , where the police officer requesting such warrant has reasonable grounds to believe that such substances will be found there *Criminal procedure* Reverse onus
	• Selling, giving or distributing narcotic drugs to a minor, without a license	Indictment • Imprisonment for a term of not less than 6 months and not exceeding 7 years (Whipping at court's discretion) (Deportation of immigrants upon completion of sentence)	• Repealed in the case of offences involving raw or prepared opium • Added for the offence of selling, giving or distributing a drug to a minor without a license

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Possession		
	• Possession	**Indictment** • Imprisonment for a term not exceeding 7 years **Summary conviction** • Imprisonment for a term of not less than 6 months and not exceeding 18 months; and • Fine of not less than $200 and not exceeding $1,000 (Deportation of immigrants upon completion of sentence)	
	• Possession of pipes, lamps or any other equipment used to prepare or use opium, except where authorized by federal authorities	**Summary conviction** • Imprisonment for a term not exceeding one month; and / or • Fine not exceeding $100	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Legal trade in narcotic drugs		
	(Physicians)		
	• **Refusal to provide information requested by federal authorities relating to the purchase, preparation or prescription of medications containing drugs**	**Summary conviction** • **Imprisonment for a term not exceeding 18 months; and / or** • **Fine of not less than $200 and not exceeding $1,000**	
	• **Prescription of drugs for non-medical purposes particularly if they are <u>not required for treatment of a disease</u>**	**Summary conviction** • **Imprisonment for a term not exceeding 18 months; and / or** • **Fine not exceeding $1,000**	
	(Pharmacists)		
	Sale of drugs for medical purposes <u>without a prescription written and signed</u> by a physician	**Summary conviction** • **Imprisonment for a term not exceeding 18 months; and / or** • **Fine of not less than $200 and not exceeding $1,000**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1923 – **Legislative Consolidation of the Act of 1911 and other amendments**	*Trafficking* • Exportation or importation, transportation within Canada, manufacture, sale, gift or distribution of drugs without a license, or its importation at a port not designated by federal authorities	Indictment • Imprisonment for a term of not less than 6 months and not exceeding 7 years; and • Fine of not less than $200 and not exceeding $1,000 Summary conviction • No amendment (The court may not impose a lesser sentence than that prescribed by the Act)	*Police powers* Powers granted to police officers in 1911 and 1922 maintained *Criminal procedure* Criminal procedures adopted between 1911 and 1922 maintained, with the exception of: • Possibility to use a portion of a fine paid by an offender to reward the person who filed the complaint against him *New criminal procedures* Right of appeal • Right of appeal from a guilty verdict and/or from a sentence in the case of a conviction by way of summary conviction eliminated for the following offences: ▪ trafficking in or possession of drugs without a license ▪ selling, giving or distributing drugs to a minor without a license
	• Selling, giving or distributing narcotic drugs to a minor, without a license	Indictment • Imprisonment for a term of not less than 6 months and not exceeding 7 years; and • Fine of not less than $200 and not exceeding $1,000 (The court may not impose a lesser sentence than that prescribed by the Act)	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Possession		Reverse onus
	• Possession	Indictment • Imprisonment for a term of not less than 6 months and not exceeding 7 years; and • Fine of not less than $200 and not exceeding $1,000 Summary conviction • No amendment (The court may not impose a lesser sentence than that prescribed by the Act)	• Procedure maintained for possession or trafficking without a license • Added in the case of offences of exporting or importing a drug without a license • Every physician charged with prescribing or administering a drug for non-therapeutic purposes is required to prove that the substance was used for medical purposes Fingerprints and criminal record
	• Possession of pipes, lamps or any other equipment used to prepare or use opium, except where authorized by federal authorities	Summary conviction • Imprisonment for a term not exceeding 3 months; and / or • Fine not exceeding $100	• Provisions of the *Identification of Criminals Act* apply to persons convicted by way of summary conviction Certificate of the federal analyst • Authorization to file in evidence a certificate prepared by a provincial analyst

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• **Possession of opium prepared for smokers or its use**	**Summary conviction** • **Imprisonment for a term not exceeding 3 months; and / or** • **Fine not exceeding $100**	
	• **Being found, without lawful excuse, in a place where opium is smoked**	**Summary conviction** • **Imprisonment for a term not exceeding 3 months; and / or** • **Fine not exceeding $100**	
	Legal trade in narcotic drugs		
	(Businesses)		
	• **Refusal to keep a record of activities, duly authorized by federal authorities, relating to the importing, exporting, manufacture, sale and distribution of narcotic drugs**	**Summary conviction** • **No amendment**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	(Physicians)		
	• **Prescription of drugs for non-medical purposes particularly if they are not required for treatment of a disease**	**Summary conviction** • **No amendment**	
	(Pharmacists)		
	• **Sale of a drug for medical purposes without a prescription written and signed by a physician or <u>the multiple renewal of such prescription</u>**	**Summary conviction** • **No amendment**	

<table>
<tr><th>Act</th><th>Offences</th><th>Penalties</th><th>Police Powers – Criminal Procedure</th></tr>
<tr><td>1925 –

Amendments to Act of 1923</td><td>Trafficking

• Exportation or importation, transportation within Canada, manufacture, giving, selling and distributing a drug without a license, or its importation at a port not designated by a federal authority

Possession

• Possession</td><td>Indictment

• No amendment

Summary conviction

• No amendment

Indictment

• No amendment

Summary conviction

• In addition to the other penalties provided for by the Act of 1923, the court may, at its discretion, impose a sentence of hard labour</td><td>Police powers

Searches

• Authorization to seize, <u>without a warrant</u>, <u>a motor vehicle, boat, rowboat or any means of transportation in which a drug was found</u>

• Addition of the power to search any person found on the premises of the search

Criminal procedure

Forfeiture of seized drugs

• Order providing for the forfeiture to the Minister of Health of a motor vehicle, boat, rowboat or any other means of transportation <u>in which a drug was found</u>

Defence arguments of physicians

• Elimination of the defence allowing a physician to prescribe a drug to a sick person or drug addict so that he could administer it to himself</td></tr>
</table>

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Legal trade in narcotic drugs (Physicians) • Prescription of drugs for non-medical purposes, particularly if they are not required for the treatment of a disease, or which <u>is designed to treat a drug addict who has developed a dependency on such a substance as a result of abusing it</u>	Indictment • Imprisonment for a term of not less than 3 months and not exceeding 5 years Summary conviction • Imprisonment for a term not exceeding 18 months; and / or • Fine of not less than $200 and not exceeding $1,000 • The court may, at its discretion, impose a sentence of hard labour	A physician may thus no longer use the defence that a patient who administers medication to himself is administering a therapeutic treatment authorized under the *Opium and Narcotic Drug Act*
	(Pharmacists) Sale of a drug for medical purposes without a prescription written and signed by a physician and <u>without authenticating the signature</u>, or renewal of such a prescription on a number of occasions	Summary conviction • No amendment	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1929 – **Legislative Consolidation of Act of 1923 and other amendments**	*Trafficking* • Exporting or importing, transporting within Canada, preparing, giving, selling and distributing without a license, importation at a port not designated by federal authorities, <u>a drug or substance the owner of which falsely claims is a drug</u>	Indictment • No amendment Summary conviction • No amendment (In addition to the other penalties provided for by the Act of 1923, the court may, at its discretion, impose a sentence of whipping)	*Police powers* Writ of assistance • Possibility of obtaining a writ of assistance in the context of a police operation conducted under the *Opium and Narcotic Drug Act* This new provision made it possible to circumvent the obligation to obtain a warrant to search a dwelling house Seizure and forfeiture • Expanded powers of seizure and forfeiture previously provided in the Act with respect to pipes, lamps and any other equipment or <u>the various parts thereof</u> used to prepare or use opium
	• Drug trafficking by mail	Indictment • Imprisonment for a term of not less than 6 months and not exceeding 7 years; and • Fine of not less than $200 and not exceeding $1,000 Summary conviction • Imprisonment for a term of not less than 6 months and not exceeding 18 months; and / or • Fine of not less than $200 and not exceeding $1,000	• Extended powers of seizure and forfeiture previously provided for in the Act with respect to money used to purchase drugs • Authorization to resort to force, if necessary, to conduct a search. Police officers can also be assisted by other persons

Act	Offences	Penalties	Police Powers – Criminal Procedure
		(In addition to the other penalties provided for by the Acts of 1923 and 1925, the court may, at its discretion, impose a sentence of whipping)	• Expansion of the power to seize and confiscate a motor vehicle, boat, rowboat or any other means of transportation used by a trafficker convicted of an offence under the Act, regardless of whether it contained drugs
	Possession • Possession of drugs (or of a substance the owner of which falsely claims is a drug), without a license, for non-therapeutic purposes	Indictment • No amendment Summary conviction • No amendment (In addition to the other penalties provided for by the Acts of 1923 and 1925, the court may, at its discretion, impose a sentence of whipping)	*Criminal procedure* Reverse onus • In any case involving trafficking in, or unlawful possession of, a drug or substance in which the owner falsely claims is a drug, Crown prosecutor is not required to establish that the accused did not have authorization duly issued by federal authorities to commit one of the offences with which he was charged
	• Possession of pipes, lamps, any other equipment or the various parts thereof used to prepare or use opium, except where authorized by federal authorities	Summary conviction • Imprisonment for a term not exceeding 3 months; and / or • Fine not exceeding $50	• If the accused alleged that he had such authorization, the burden of proof was on him
	• Possession of opium prepared for		

Act	Offences	Penalties	Police Powers – Criminal Procedure
•	smokers or its use	Summary conviction • Imprisonment for a term not exceeding 3 months; and / or • Fine not exceeding $50	Certificate of the federal analyst • Amendments to the procedure for admissibility in evidence of the certificate of the federal or provincial analyst, stipulating that, henceforth, that document would constitute *prima facie* and peremptory evidence of the status of the person giving or issuing it
	• Obtaining drugs from two physicians	Summary conviction • Fine not exceeding $500 to which may be added a term of imprisonment not exceeding 12 months for failure to pay	• In the circumstances, proof of the appointment of that analyst or authentication of his signature was not necessary
	Legal trade in narcotic drugs (Physicians) Prescription of drugs for non-medical purposes, particularly if they are not required for the treatment of a disease, or which is designed to treat a drug addict who has developed a dependency on such a substance as a result of abusing it	Summary conviction (No amendment) (The court may not impose a lesser sentence than that prescribed by the Act)	Writ of *certiorari* • Repeal of the provision eliminating recourse to a writ of *certiorari* Right of appeal • Expanded the prohibition against appealing from a guilty verdict and/or sentence in the case of a summary conviction for the following offence: ▪ possession of, or trafficking in, a substance the owner of which falsely claims is a drug
	(Pharmacists)		

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• Selling or administering a product containing quantities of drugs exceeding the limits prescribed by the Act and without appropriate labelling to a child less than 2 years of age	Summary conviction (First offence) • Fine not exceeding $100 (Subsequent offences) • Imprisonment for a term not exceeding 3 months; and / or • Fine not exceeding $100	
	• Refusal to keep a record of drug purchases and sales, the making of medications containing such substances and the renewal of prescriptions issued by a physician	Summary conviction • Imprisonment for a term not exceeding <u>18 months</u>; and / or • Fine of not less than $200 and not exceeding $1,000	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1932 – Amendments to Act of 1929	*No amendment*	*No amendment*	*Criminal procedure* Right of appeal • **Significant expansion of the prohibition from appealing of a guilty verdict and/or a sentence in the case of a <u>summary conviction</u> for the following offences:** ▪ **Prescribing of a drug for non-medical purposes, particularly if they are not required for the treatment of a disease, or which is intended to treat a drug addict who has developed a dependency to such a substance as a result of abusing it (physicians);** ▪ **refusal to provide information required by federal authorities relating to the purpose, preparation of prescription of medications containing drugs (physicians);** ▪ **obtaining drugs from two physicians;**

Act	Offences	Penalties	Police Powers – Criminal Procedure
			▪ selling or administering a product containing quantities of drugs exceeding the limits prescribed by the Act and without appropriate labelling to a child under 2 years of age (pharmacists); ▪ refusal to keep a record of drug purchases and sales, the preparation of medications containing such substances and the renewals of prescriptions issued by a physician (pharmacists); ▪ unlawful possession of pipes, lamps and any other equipment or the various parts thereof used to prepare or use opium; and ▪ drug trafficking by mail

Act	Offences	Penalties	Police Powers – Criminal Procedure
1938 – **Amendments to Act of 1929**	*Trafficking* • **Cultivation of the opium poppy or cannabis sativa without a licence**	**Indictment** • **Imprisonment for a term of not less than 6 months and not exceeding 7 years** • **Fine of not less than $200 and not exceeding $1,000** **Summary conviction** • **Imprisonment for a term of not less than 6 months and not exceeding 18 months** • **Fine of not less than $200 and not exceeding $1,000** **(Deportation of immigrants – whipping)**	*Criminal procedure* **Right of appeal** ▪ **Repeal the prohibition against appealing from a guilty verdict and/or sentence in the case of a <u>summary conviction</u> for the following offence:** ▪ **obtaining drugs from two physicians**
	Possession **No amendment** *Legal trade in narcotic drugs* **No amendment**		

Act	Offences	Penalties	Police Powers – Criminal Procedure
1946 – **Amendments to Act of 1929**	*Trafficking* • **Selling, giving, <u>illegally administering</u> or distributing drugs to a minor (1921)**	**No amendment**	*Criminal procedure* **Reverse onus** • **Applicable to the offence of cultivation of cannabis sativa or the opium poppy without a licence**

Act	Offences	Penalties	Police Powers – Criminal Procedure
1954 – **Amendments to Act of 1929**	*Trafficking*	*(Repealed sentence of forced labour)* *(Repealed provisions respecting the deportation of immigrants . They were transferred to the Immigration Act in 1952, but still applied to drug offences)*	*Police powers* **Seizure and forfeiture** • **Amended powers of seizure and forfeiture to exclude the equipment used to prepare or smoke opium (offences repealed)** *Criminal procedure*
	• **Importation, exportation, manufacture, sale, administering, transportation, delivery and distribution of a drug or substance the owner of which claims is a narcotic drug**	**Indictment** • **Imprisonment for a term not exceeding 14 years** • **Whipping (at court's discretion)**	**Reverse onus** • **Possession for the purpose of trafficking** ▪ **In every criminal prosecution involving possession for the purpose of trafficking, Crown prosecutor was required to prove that the accused had been illegally in possession of the drug. Otherwise, he was acquitted**
	• **Possession for the purpose of trafficking**	**Indictment** • **Imprisonment for a term not exceeding 14 years** • **Whipping (at court's discretion)**	▪ **In the contrary case, the respondent had to prove that he did not possess the substance for the purpose of trafficking. If he did so, he was convicted of possession, otherwise of trafficking**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• **Cultivation of the opium poppy or cannabis sativa without a license**	**No amendment**	
	(Repeal of the offence of selling, giving or administering a drug to a minor)		
	(Repeal of the offence of drug trafficking by mail)		
	Possession		
	Possession	**Indictment** • **Imprisonment for a term of not less than 6 months and not exceeding 7 years** **Summary conviction** • **Imprisonment for a term of not less than 6 months and not exceeding 18 months** **(Whipping (at court's discretion))** *(The court may not impose a lesser sentence than the minimum prescribed by the Act)*	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	(Repeal of the offence of possessing opium prepared for smokers or use of such a substance) *(Repeal of the offence of being found in a place where opium is smoked)* *(Repeal of the offence of possession of pipes, lamps or any other equipment and the various parts thereof used to prepare or use opium)* *Legal trade in narcotic drugs* • **No amendment**		

Act	Offences	Penalties	Police Powers – Criminal Procedure
1961 –	*Trafficking*	*(Repeal of sentence of whipping)*	*Police powers*
Narcotic Control Act	• Illegal activities defined in the Act of 1954, with the exception of the offences of importing and exporting	Indictment • Imprisonment for a term not exceeding 25 years (life)	Writ of assistance • Provision maintained without amendment
	• As was the case in the former acts, this offence was extended to include substances falsely presented by a trafficker as being scheduled drugs		Searches • Continuation of provisions authorizing searches <u>without a warrant</u> of any place and of persons found there (with the exception of a dwelling house) where police officers have reasonable grounds to believe there are drugs or equipment used to make or use them
	• Exporting and importing	Indictment • Imprisonment for a term of not less than 7 years and not exceeding 25 years (life)	• Continuation of provisions authorizing the use of force, if necessary, to conduct a search, stipulating that a police officer may force entry, break in a wall or ceiling or break objects that might contain drugs
	• Possession for the purpose of trafficking	Indictment • Imprisonment for a term not exceeding 25 years (life)	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• **Cultivation the opium poppy or cannabis sativa without a licence**	**Indictment** • **Imprisonment for a term not exceeding 7 years**	• **Continuation of the procedure providing that a police officer may obtain the assistance of a person whom he designates to carry a search**
	Possession		
	Possession	**Indictment** • **Imprisonment for a term not exceeding 7 years**	*Criminal procedure* **Reverse onus** • **Continuation of the procedure adopted in 1954 in the case of the offence of possession for the purpose of trafficking, with a few amendments to clarify the procedure and guarantee greater compliance with the principle of the presumption of innocence**
	Legal trade in narcotic drugs		
	• **Transfer to the regulations of the statutory provisions enacted between 1911 and 1946 respecting the legal trade in drugs** • **Regulations made by the Governor in Council respecting the legitimate activities of businesses, physicians and pharmacists involving sale, production, distribution, administration, prescription, record keeping and offences**	**Summary conviction** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $500**	• **Continuation of the procedure providing that an accused must prove that he acted lawfully, for therapeutic or scientific reasons <u>under a government authorization</u>** **Certificate of a federal or provincial analyst** • **Continuation of this provision, with the stipulation that the analyst would be appointed under the *Food and Drugs Act*.**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Preventive detention • For offences of trafficking, possession for the purpose of trafficking, exporting or importing drugs, the court may order the accused placed in preventive detention for an indeterminate period of time, in lieu of any other sentence that might be imposed (This provision was never proclaimed in force) *Treatment* • In the case of the offences regarding possession, trafficking, possession for the purpose of trafficking and importing or exporting drugs, the court, may, upon application by the Crown prosecutor, remand the accused to custody for examination to determine whether he is eligible for an addiction treatment program • If such is the case, the accused shall be sentenced to custody for treatment for an indeterminate period of time in lieu of any other sentence provided for by the Act		Forfeiture • Continuation of the forfeiture to the Minister of Health and Welfare of drugs, syringes, needles, equipment and money used to use, make or purchase such substance following an offence of possession, trafficking, possession for the purpose of trafficking or import/export *(The minister may dispose of the substances in the manner provided for by regulation)* • Continuation of the procedure allowing forfeiture of any motor vehicle, aircraft, ship or other means of transportation used for the purpose of trafficking, exporting or importing drugs Restitution • Continuation of the system providing for an order to restore drugs or objects related to the making or use of drugs prior to their forfeiture to the Minister of Health and Welfare But, certain criteria apply before a court orders restitution:

Act	Offences	Penalties	Police Powers – Criminal Procedure
		• In the case of a first offence, preventive detention may not exceed 10 years • The accused has a right of appeal, is subject to the *Parole Act* and, at any time, may be referred to preventive detention if he uses drugs during his probation period • Where a province adopts a preventive detention policy and an addiction treatment program (in cases not involving an offence under the Act), the federal government may enter into an agreement with the competent provincial authorities to transfer addicts to specialized federal institutions. (These provisions were never proclaimed in force)	▪ Application must be made to the court not later than two months after the seizure; ▪ If it is satisfied that the applicant is not involved in the offence and if it is satisfied that they will not be necessary to the prosecution of an investigation or criminal case, the court shall immediately return the drugs or objects seized, ▪ However, where the court decides otherwise, they will not be restored until the end of the trial or upon expiry of a period of four months if no prosecution is commenced against the accused The applicant has a right of appeal Application by third parties • Creation of a system authorizing a third party (a person who have not been involved in the offence) to apply to the court for an order to restore an aircraft, motor vehicle, ship or any other means of transportation.

Act	Offences	Penalties	Police Powers – Criminal Procedure
			The procedures that applied for the issuing of such an order were similar to those described above for the return of seized objects. The third party had a right of appeal Right of appeal • Repeal of the prohibition to appeal from a guilty verdict or a sentence for certain offences Fingerprints and criminal record • Repeal of the provision making the *Identification of Criminals Act* applicable to persons convicted by summary conviction (1923)

Act	Offences	Penalties	Police Powers – Criminal Procedure
1961 – **Food and Drugs Act**	*Addition of Part III to the Food and Drugs Act – Barbiturates and amphetamines* **(Controlled drugs – Schedule G)** *Trafficking* • **Manufacture, sale, transportation, exportation, importation or delivery of a controlled drug without the authorization of federal authorities** *(Exclusion of the administration or distribution of such substances)*	**Indictment** • **Imprisonment for a term not exceeding 10 years** **Summary conviction** • **Imprisonment for a term not exceeding 18 months**	*Police powers* • **Police powers similar to those provided for by the *Narcotic Control Act* of 1961, which, however, <u>do not apply to possession of controlled drugs</u>** *Criminal procedure* • **Criminal procedures similar to those provided for by the *Narcotic Control Act* of 1961, which, however, <u>do not apply to the possession of controlled drugs</u>**
	Possession for the purpose of trafficking • **Possession for the purpose of trafficking**	**Indictment** • **Imprisonment for a term not exceeding 10 years** **Summary conviction** • **Imprisonment for a term not exceeding 18 months**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Possession • Possession is not an offence		
	Legal trade in controlled drugs • Regulations made by the Governor in Council	Summary conviction • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $500	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1969 – **Food and Drugs Act**	*Addition of Part IV to the Food and Drugs Act – Hallucinogenics* (Restricted drugs – Schedule J) *Trafficking* • Manufacture, sale, transportation, exportation, importation or delivery of a restricted drug without the authorization of federal authorities *(Exclusion of administration or distribution of such substances)*	Indictment • Imprisonment for a term not exceeding 10 years Summary conviction • Imprisonment for a term not exceeding 18 months	*Police powers* • Police powers similar to those provided for in Part III. <u>Unlike those provided for in that part, they also apply to possession of restricted drugs</u> *Criminal procedure* • Criminal procedures similar to those provided for by Part III. <u>Unlike those provided for in that part, they also apply to possession of restricted drugs</u>
	Possession for the purpose of trafficking • Possession for the purpose of trafficking	Indictment • Imprisonment for a term not exceeding 10 years Summary conviction • Imprisonment for a term not exceeding 18 months	Certificate of the federal or provincial analyst • Amendment to the procedure for admissibility of the certificate of a federal or provincial analyst at trial Under the Act of 1961, a court could admit into evidence the certificate of the analyst appointed under the *Food and Drugs Act*. That document constituted *prima facie* and peremptory evidence of the status of the person who gave or issued it.

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Possession • Possession	Indictment • Imprisonment for a term not exceeding 3 years; or • Fine of $5,000 Summary conviction *First offence* • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000 *Subsequent offences* • Imprisonment for a term not exceeding one year; and / or • Fine not exceeding $2,000	**In the circumstances, it was neither necessary to prove the appointment of that person or to authenticate his signature.** **In 1969, this procedure was amended to enable Crown prosecutor to prove that status orally under oath, by affidavit or by solemn declaration of the person who signed the certificate. That person did not have to appear in court** **However, a judge could require the analyst to appear before him to be examined or cross-examined so as to better assess the information contained in the affidavit or solemn declaration**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Legal trade in restricted drugs		
	• **Regulations made by the Governor in Council**	**Summary conviction** • **Imprisonment for a term not exceeding 18 months; and / or** • **Fine of $500**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1969 – **Amendments to Narcotic Control Act**	*Possession*	**Indictment** • **Imprisonment for a term not exceeding 7 years** **Summary conviction** *First offence* • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $1,000** *Subsequent offences* • **Imprisonment for a term not exceeding one year; and / or** • **Fine not exceeding $2,000**	*Criminal procedure* **Certificate of the analyst** • **Amendments identical to those made to the *Food and Drugs Act***

Act	Offences	Penalties	Police Powers – Criminal Procedure
Act of 1985 – **Amendments to Act of 1961**	*Possession* • **Disclosure of previous prescriptions to a physician** *(This new offence was designed to prevent a person from consulting two physicians at the same time to obtain drugs. It is similar to the provision introduced in the Opium and Narcotic Drug Act in 1929 prohibiting anyone from obtaining drugs from two physicians)*	**Indictment** • **Imprisonment for a term not exceeding 7 years** **Summary conviction** **(First offence)** • **Imprisonment for a term not exceeding 6 months; or** • **Fine not exceeding $1,000** **(Second offence)** • **Imprisonment for a term not exceeding one year; or** • **Fine not exceeding $2,000**	*Police powers* **Searches** • **Abolition of the writ of assistance** *Criminal procedure* • **Repeal of the reverse onus provision for the offence of possession of drugs for the purpose of trafficking**

Act	Offences	Penalties	Police Powers – Criminal Procedure
Act of 1988 –	*Trafficking*		*Police powers*
Amendments to Act of 1961	Exporting and importing	Indictment • Imprisonment for a term not exceeding 25 years (life) *(In 1987, the Supreme Court of Canada ruled in R. v. Smith that it was unconstitutional to impose a sentence of imprisonment for a term of not less than 7 years)*	The *Criminal Code* provisions concerning search, seizure and detention powers relating to the offences of possession of property obtained through drug trafficking and laundering the proceeds of crime also apply to the *Narcotic Control Act* *Criminal procedure* The *Criminal Code* provisions concerning forfeiture and restoration, third party applications and the management of property seized in relation to the offences of possession of property obtained through drug trafficking and laundering the proceeds of crime also apply to the *Narcotic Control Act*
	• Possessions of property obtained through drug trafficking *(This new offence applies to the illegal activities of cultivating, trafficking in, exporting and importing drugs in Canada or in a foreign country where those offences are committed by Canadian citizens)*	(Value of more than $1,000) Indictment • Imprisonment for a term not exceeding 10 years • (Value of less of than $1,000) Indictment • Imprisonment for a term not exceeding 2 years	

Act	Offences	Penalties	Police Powers – Criminal Procedure
•		**Summary conviction** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $2,000**	
	• **Laundering the proceeds of crime** *(This new offence applies to the illegal activities of cultivating, trafficking in, exporting and importing drugs in Canada or in a foreign country where those offences are committed by Canadian citizens)*	**Indictment** • **Imprisonment for a term not exceeding 10 years** **Summary conviction** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $2,000**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1996 – **Controlled Drugs and Substances Act**	Schedule I: Opiates (opium, morphine, heroin, codeine, cocaine, morphinans, etc.) Schedule II: Cannabis (marijuana), hashish, cannabinol, etc. Schedule III: Amphetamines and hallucinogenics (mescaline, LSD, DET, PCP) Schedule IV: Barbiturates, benzodiazepines (Seconal, Luminal, Valium and Librium) and anabolic steroids Schedule V: Other substances giving rise to abuse Schedule VI: Precursors (simili-drugs and designer drugs) Schedule VII: Cannabis trafficking • Under 3 kg of cannabis (marijuana) or hashish Schedule VIII: Cannabis possession Under: • 1 gram of hashish; or • 30 grams of cannabis		*Police powers* Search and seizure • Repeal of the right to conduct searches and seizures without a warrant • Search or seizure <u>without a warrant</u> allowed in exigent circumstancts • Continuation of procedures for the seizure of a means of transportation, an object or a designated substance with the use of force, if necessary, or assistance of persons other than police officers However, following a search or seizure with or without a warrant, police officers are required to send a report to the justice of the peace and to the Minister of Health stating: ▪ the place of the search; ▪ the designated substance; and ▪ the place where that substance was stored

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Trafficking or possession for the purpose of trafficking • **Administration, gift, transportation, dispatch, and delivery of a designated substance, or any other activity outside the regulatory framework** *(Designated substance includes: natural and synthetic drugs, any other substance the owner of which falsely claims is a drug and objects used to use, make or store a drug)*		• **Extension of powers of search already provided for by the *Narcotic Control Act* to:** ▪ **real property and those modified for criminal purposes (premises of criminal organizations); and** ▪ **where police officers have reasonable grounds, to any other object which might establish evidence of an offence**
	Schedules I and II	**Indictment** • **Imprisonment for a term not exceeding 25 years (life)**	• **Validity of a search warrant in a province other than the one where it was given** **Policy immunity**
	Schedule III	**Indictment** • **Imprisonment for a term not exceeding 10 years** **Summary conviction** • **Imprisonment for a term not exceeding 18 months**	• **In 1996, the *Controlled Drugs and Substances Act* allowed the Governor in Council to authorize by regulations police officers to possess and traffic in designated substances sting operations** *(Currently, sections 4, 5, 6, 7, 8 and 9 of the CDSA prohibit possession, possession for the purpose of trafficking, importing, exporting, producing narcotics, possession of*

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Schedule IV	Indictment • Imprisonment for a term not exceeding 3 years Summary conviction • Imprisonment for a term not exceeding one year	*property obtained by criminal activity and laundering of proceeds of crime.* *However, section 3 of the Narcotic Control Regulations authorizes inspectors and police officers to possess drugs for the purposes of or in relation to their duties. This provision existed in the regulations relating to the Narcotic Control Act to prevent a police officer from being charged with possession following a search)*
	Schedule VII	Indictment • Imprisonment for a term not exceeding 5 years less a day	*In addition, the police enforcement regulations made under the Controlled Drugs and Substances Act provides for an exemption for peace officers from the application of sections 4, 5, 6, 7 8 and 9 of the Act. In that case, the persons concerned by that provision must at all times be active members of a police force and must be found in the performance of their duties during the investigation in question)*
	• Cultivation or production		
	Schedules *I* and *II* (except cannabis)	Indictment • Imprisonment for a term not exceeding 25 years (life)	
	Cannabis	Indictment • Imprisonment for a term not exceeding 7 years	• **In December 2001, the *Criminal Code* was amended (Bill C-24) to grant police officers, on certain conditions, legal immunity when required to commit an indictable**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Schedule III	Indictment • Imprisonment for a term not exceeding 10 years Summary conviction • Imprisonment for a term not exceeding 18 months	offence in the course of an investigation or operation to infiltrate a criminal or terrorist organization. However, they are granted no legal immunity if they commit the following offences: murder, manslaughter, bodily harm, obstructing the administration of justice and sexual assault.
	Schedule IV	Indictment • Imprisonment for a term not exceeding 3 years Summary conviction • Imprisonment for a term not exceeding one year	*Criminal procedure* Sentencing • Definition of guiding principles for sentencing (compliance with the Act, maintaining a just and peaceful society, social reintegration, treatment and reparation of harm caused to victims)
	▪ Exporting and importing Schedules I and II	Indictment • Imprisonment for life (25 years)	• Definition of aggravating circumstances: ▪ use of a weapon;
	Schedules III and VI	Indictment • Imprisonment for a term not exceeding 10 years Summary conviction	▪ resorting to violence; ▪ trafficking in a substance designated under Schedules I, II, III and IV with a minor or on a school ground

Act	Offences	Penalties	Police Powers – Criminal Procedure
		• Imprisonment for a term not exceeding 18 months	▪ prior convictions under the Act; ▪ and use of a minor to commit an offence
	Schedules IV or V	Indictment • Imprisonment for a term not exceeding 3 years Summary conviction • Imprisonment for a term not exceeding one year	• Any court that decides not to impose a sentence of imprisonment in cases involving aggravating circumstances must give reasons for that decision Forfeiture • Continuation of the provision allowing forfeiture of: ▪ designated substances; ▪ means of transportation and property acquired by drug trafficking (expands powers to include ordinary real property or real property modified for criminal purposes); and ▪ proceeds of crime • Continuation of the procedure regarding applications by third parties, stipulating, however, that the application must be made by Crown prosecutor. He must prove that the property is necessary to

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• Possession of property obtained through trafficking in designated substances *(This offence applies to the illegal activities of cultivating, trafficking in, exporting and importing drugs in Canada or in a foreign country where those offences are committed by Canadian citizens)*	(Value of more than $1,000) Indictment • Imprisonment for a term not exceeding 10 years (Value of less of than $1,000) Indictment • Imprisonment for a term not exceeding 2 years Summary conviction • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $2,000	that the property is necessary to the investigation and prosecution. Otherwise, property is automatically returned to the owner • Creation of a restraint order in respect of offence-related property, real property and proceeds of crime • Creation of a separate procedure for restoring or disposing of designated substances in order to clarify the provisions of the *Narcotic Control Act* in this respect • Possibility that property or proceeds of crime may be forfeited to the Minister of Public Works and Government Services Canada or the <u>Solicitor General of a province.</u>
	• Laundering of the proceeds of crime *(This n offence applies to the illegal activities of cultivating, trafficking in, exporting and importing drugs in Canada or in a foreign country where those offences are committed by Canadian citizens and is more particularly aimed at money laundering)*	Indictment • Imprisonment for a term not exceeding 10 years Summary conviction • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $2,000	Federal inspectors • Definition of the powers of inspectors appointed by the federal government to enforce regulations governing legal trade of designated substances. Inspectors may:

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Possession • Possession Schedule I	Indictment • Imprisonment for a term not exceeding 7 years Summary conviction • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000	▪ enter (with the consent of one of the occupants), examine and search, <u>without a warrant</u> any place, equipment or receptacle used to produce or store a designated substance or precursor; ▪ search any dwelling house, <u>with a warrant</u> used to produce or store a designated substance or precursor;
	Schedule II	Indictment • Imprisonment for a term not exceeding 5 years less a day Summary conviction (First offence) • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000	▪ take away any computer hardware used to store information on designated substances or precursors; ▪ seize such substances if necessary and return them in accordance with the regulations; and ▪ use force or be accompanied by a police officer to execute their warrant **Arbitration and designated regulations** • Creation of a special procedure - the Governor in Council may designate regulations – known as "designated regulations" – the

Act	Offences	Penalties	Police Powers – Criminal Procedure
		(Subsequent offences) • Imprisonment for a term not exceeding one year; and / or • Fine not exceeding $2,000	contravention of which is dealt with under special administrative orders • Creates an arbitration mechanism enabling pharmacists, physicians and businesses to dispute orders made under designated regulations by the Department of Health and following an investigation by an investigator into offences under the designated regulations
	Schedule VIII	Summary conviction • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000	
	Schedule III	Indictment • Imprisonment for a term not exceeding 3 years Summary conviction (First offence) • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000	

Act	Offences	Penalties	Police Powers – Criminal Procedure
		(Subsequent offences) • Imprisonment for a term not exceeding one year; and / or • Fine not exceeding of $2,000	
	• Disclosure of previous prescriptions to a physician (1985)		
	Schedule I	Indictment • Imprisonment for a term not exceeding 7 years Summary conviction (First offence) • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000 (Subsequent offences) • Imprisonment for a term not exceeding one year; and / or • Fine not exceeding $2,000	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Schedule II	**Indictment** • Imprisonment for a term not exceeding 5 years less a day **Summary conviction** (First offence) • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000 (Subsequent offences) • Imprisonment for a term not exceeding one year; and / or • Fine not exceeding $2,000	
	Schedule III	**Indictment** • Imprisonment for a term not exceeding 3 years	

Act	Offences	Penalties	Police Powers – Criminal Procedure
		Summary conviction **(First offence)** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $1,000** **(Subsequent offences)** • **Imprisonment for a term not exceeding one year; and / or** • **Fine not exceeding $2,000**	
	Schedule IV	**Indictment** • **Imprisonment for a term not exceeding 18 months** **Summary conviction** **(First offence)** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $1,000**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
		(Subsequent offences) • Imprisonment for a term not exceeding one year; and / or • Fine not exceeding $2,000	
	Legal trade in narcotic drugs • Regulations made by the Governor in Council	Indictment • Imprisonment for a term not exceeding 3 years; and / or • Fine not exceeding $5,000 Summary conviction • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000	
	Therapeutic use of cannabis • Authorization to use this designated substance for therapeutic or scientific purposes Under section 56 of the Act, the Minister of Health may on such terms and conditions as he may		

Act	Offences	Penalties	Police Powers – Criminal Procedure
•	set, exempt from the application of all or any part of the Act any person or class of persons or any designated substance referred to in a schedule to the Act In July 2000, this procedure was ruled unconstitutional by the Ontario Court of Appeal in *R. v. Parker*. At the time, the court held that the minister's power to grant an exemption to allow the use of marijuana or other drugs for therapeutic purposes was too broad and contrary to section 7 of the *Canadian Charter of Rights and Freedoms* (liberty and security of the person, fundamental justice) To correct the situation, the federal government made regulations in July 2001 allowing the therapeutic use of cannabis *Preventive detention (1961)* • Provision repealed *Detention for treatment (1961)* • Provision repealed		

Sénat Senate

CANADA

LE CANNABIS :

POSITIONS POUR UN RÉGIME DE POLITIQUE PUBLIQUE POUR LE CANADA

RAPPORT DU COMITÉ SPÉCIAL DU SÉNAT SUR LES DROGUES ILLICITES

VOLUME IV : ANNEXES

PRÉSIDENT

PIERRE CLAUDE NOLIN

VICE-PRÉSIDENT

COLIN KENNY

SEPTEMBRE 2002

ANNEXE I

MEMBRES ET PERSONNEL DU COMITÉ SPÉCIAL DU SÉNAT SUR LES DROGUES ILLICITES

1. MEMBRES DU COMITÉ SPÉCIAL DU SÉNAT SUR LES DROGUES ILLICITES

L'Honorable Pierre Claude Nolin
(Président)

L'Honorable Colin Kenny
(Vice-président)

L'Honorable Tommy Banks

L'Honorable Eileen Rossiter

L'Honorable Shirley Maheu

L'Honorable John Lynch-Staunton *

L'Honorable Sharon Carstairs* **

L'Honorable Noël A. Kinsella *

L'Honorable Fernand Robichaud *

2. AUTRES SÉNATEURS AYANT PARTICIPÉ AUX TRAVAUX DU COMITÉ

L'Honorable Michel Biron

L'Honorable Laurier LaPierre

L'Honorable Pat Carney

L'Honorable Jean Lapointe

L'Honorable Thelma Chalifoux

L'Honorable Edward M. Lawson

L'Honorable Ione Christensen

L'Honorable Lorna Milne

L'Honorable Ethel M. Cochrane

L'Honorable Yves Morin

L'Honorable Pierre De Bané

L'Honorable Lucie Pépin ***

L'Honorable Consiglio Di Nino

L'Honorable Marie-P. Poulin

L'Honorable Joyce Fairbairn

L'Honorable Marcel Prud'homme

L'Honorable Sheila Finestone

L'Honorable Gerry St. Germain

L'Honorable J. Michael Forrestall

L'Honorable Peter A. Stollery

L'Honorable Jerahmiel S. Grafstein

L'Honorable Terry Stratton

L'Honorable Mobina S.B. Jaffer

L'Honorable John Wiebe

L'Honorable Lois M. Wilson

* Membres d'office
** L'Honorable Sharon Carstairs a été membre du Comité d'avril 2000 à octobre 2000
*** L'Honorable Lucie Pépin a été membre du Comité d'avril 2000 à octobre 2000.

3. PERSONNEL DU COMITÉ SPÉCIAL SUR LES DROGUES ILLICITES

3.1 GREFFIERS

Blair Armitage
(Greffier)

Daniel Charbonneau
(Greffier suppléant)

Adam Thompson
(Greffier suppléant)

3.2 RECHERCHE

Daniel Sansfaçon
(Directeur de la recherche)

Gérald Lafrenière
(Analyste -- Bibliothèque du Parlement)

Chantal Collin
(Analyste -- Bibliothèque du Parlement)

Lyne Casavant
(Bibliothèque du Parlement)

Diane Leduc
(Bibliothèque du Parlement)

Benjamin Dolin
(Bibliothèque du Parlement)

Martine Leroux
(Bureau de la sénatrice Shirley Maheu)

Nancy Miller Chenier
(Bibliothèque du Parlement)

Robin MacKay
(Bibliothèque du Parlement)

François Dubois
(Bureau du sénateur Pierre Claude Nolin)

Jeffrey Myers
(Comité spécial du Sénat sur les drogues illicites)

Mollie Dunsmuir
(Bibliothèque du Parlement)

Sonya Norris
(Bibliothèque du Parlement)

Daniel Dupras
(Bibliothèque du Parlement)

Emmanuel Préville
(Bibliothèque du Parlement)

David Goetz
(Bibliothèque du Parlement)

Jay Sinha
(Bibliothèque du Parlement)

Anthony Jackson
(Bibliothèque du Parlement)

Leah Spicer
(Bibliothèque du Parlement)

Rebecca Jesseman
(Comité spécial sur les drogues illicites)

Barbara B. Wheelock
(Bureau de la sénatrice Eileen Rossiter)

3.3 ADMINISTRATION

Lise Bouchard
(Direction des comités et de la législation privée)

Keli Hogan
(Direction des comités et de la législation privée)

Nicole Bouchard
(Bureau du sénateur Pierre Claude Nolin)

Mireille Khouri
(Direction des comités et de la législation privée)

Martine de Launière
(Comité spécial du Sénat sur les drogues illictes)

Nathalie Lemay-Paquette
(Direction des comités et de la législation privée)

Krista Durrell
(Direction des comités et de la législation privée)

Brigitte Martineau
(Direction des comités et de la législation privée)

Liliane Poiré
(Bureau du sénateur Pierre Claude Nolin)

3.4 COMMUNICATIONS

Diane Boucher et son équipe
(Direction des communications du Sénat)

Jean-Guy Desgagné
(Conseiller spécial – Comité du sénat sur les drogues illicites)

David Newman
(Newman Communications)

3.5 INTERPRÈTES, TRADUCTEURS ET STÉNOGRAPHES

Sténographes officiels du Sénat
(Direction des débats et publications du Sénat)

Traducteurs
(Bureau de la traduction)

Interprètes
(Bureau de la traduction)

Thérèse Alier
(Éditrice privée)

ANNEXE II

LISTE DES TÉMOINS

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Cathy Airth	**Santé Canada** Directrice intérimaire, Bureau de la stratégie antidrogue canadienne, Direction générale de la santé environnementale et de la sécurité des consommateurs (Ottawa, Ontario)	**10 juin 2002** **Ottawa, Ontario**
Bruce Alexander	**Université Simon Fraser** Professeur, Département de psychologie (Victoria, Colombie-Britannique)	**23 avril 2001** **Ottawa, Ontario**
Lindsay Armitage	**À titre personnel**	**13 mai 2002** **Regina, Saskatchewan**
Lyell Armitage	**District de santé de Regina** Ancien directeur, Services aux alcooliques et aux toxicomanes (Regina, Saskatchewan) **Expert invité lors d'une assemblée publique**	**13 mai 2002** **Regina, Saskatchewan**
Guy Ati Dion	**Université de Montréal** (Montréal, Québec)	**29 octobre 2001** **Ottawa, Ontario**
George Bailey	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Linda Barnes	**Ville de Richmond** Conseillère municipale (Richmond, Colombie-Britannique)	**14 mai 2002** **Richmond, Colombie-Britannique**
Pat Baumet	**À titre personnel**	**13 mai 2002** **Regina, Saskatchewan**
David Beall	**Commission interaméricaine de lutte contre l'abus des drogues** Secrétaire exécutif (Washington (D.C.) – États-Unis d'Amérique)	**18 mars 2002** **Ottawa, Ontario**
Line Beauchesne	**Université d'Ottawa** Professeure, Département de criminologie (Ottawa, Ontario)	**16 octobre 2000** **Ottawa, Ontario**
Denise Beaudoin	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
Patricia Begin	**Centre national de prévention du crime** Directrice, Recherche et Évaluation (Ottawa, Ontario)	**10 juin 2002** **Ottawa, Ontario**
Mohamed Ben Amar	**Université de Montréal** Professeur de pharmacologie et toxicologie (Montréal, Québec)	**28 mai 2001** **Ottawa, Ontario**
Chris Bennett	**À titre personnel**	**7 novembre 2001 et 14 mai 2002** **Vancouver et Richmond, Colombie-Britannique**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Marie-Andrée Bertrand	**Université de Montréal** Professeure émérite de criminologie (Montréal, Québec) **Expert invité lors d'une assemblée publique (Montréal)**	**23 avril 2001 et 30 mai 2002** **Ottawa, Ontario** **Montréal, Québec**
Beverly Best	**Village de Salisbury** Conseillère municipale (Salisbury, Nouveau-Brunswick)	**5 juin 2002** **Moncton, Nouveau-Brunswick**
Hilary Black	**B.C. Compassion Club Society** Directrice et fondatrice (Vancouver, Colombie-Britannique)	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Bill Blanchard	**Gendarmerie Royale du Canada** Sergent (Regina, Saskatchewan) **Expert invité lors d'une assemblée publique**	**13 mai 2002** **Regina, Saskatchewan**
Guillaume Blouin-Beaudoin	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
Ron Bocking	**À titre personnel**	**13 mai 2002** **Regina, Saskatchewan**
Tim Boekhout Van Solinge	**Université d'Utrecht** Recherchiste en criminologie (Utrecht, Pays-Bas)	**19 novembre 2001** **Ottawa, Ontario**
Renee Boje	**À titre personnel**	**14 mai 2002** **Vancouver, Colombie-Britannique**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Stephen Bolton	**Ministère des Affaires étrangères et du Commerce international, direction du crime international** Agent, Drogues internationales, Direction du crime international (Ottawa, Ontario)	**18 mars 2002** **Ottawa, Ontario**
Yvan Bombardier	**CACTUS** Intervenant (Montréal, Québec)	**30 mai 2002 et 31 mai 2002** **Montréal, Québec**
Pierre-Charles Boudrias	**Centre Dollard-Cormier** (Montréal, Québec)	**31 mai 2002** **Montréal, Québec**
David Bourgeois	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**
Michael J. Boyd	**Association canadienne des chefs de police** Président du Comité sur la toxicomanie et sous-chef du Service de police de Toronto (Ottawa, Ontario)	**11 mars 2002** **Ottawa, Ontario**
Neil Boyd	**Université Simon Fraser** Professeur, Département de criminologie (Victoria, Colombie-Britannique)	**16 octobre 2000** **Ottawa, Ontario**
Al Breau	**Village de Salisbury** Membre de la Salisbury Municipal Drug Strategy and Addiction (Salisbury, Nouveau-Brunswick) **Expert invité lors d'une assemblée publique**	**5 juin 2002** **Moncton, Nouveau-Brunswick**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Serge Brochu	**Université de Montréal** Professeur et directeur du Centre international de criminologie comparée (Montréal, Québec)	**10 décembre 2001** **Ottawa, Ontario**
Nick Brusatore	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**
Perry Bulwer	**À titre personnel**	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Fred Burford	**À titre individuel**	**10 septembre 2001** **Toronto, Ontario**
Michele Burque	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
Tracy Butler	**Salvation Army Harbour Light Addiction and Rehabilitation Treatment Centre, HCC St. John's** Directrice de programme (Saint-Jean, Terre-Neuve-et-Labrador)	**4 juin 2002** **Mount-Pearl, Terre-Neuve-et-Labrador**
Bill Campbell	**Société médicale canadienne sur l'addiction** Président (Ottawa, Ontario)	**11 mars 2002** **Ottawa, Ontario**
Chris Carnell	**À titre personnel**	**13 mai 2002** **Regina, Saskatchewan**
Nicolas Carrier	**À titre personnel**	**30 mai 2002** **Montréal, Québec**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
James Anthony Cavalier	**À titre individuel**	**10 septembre 2001** **Toronto, Ontario**
Walter Cavalieri	**Toronto Harm Reduction Task Force** (Toronto, Ontario)	**10 septembre 2001** **Toronto, Ontario**
Jean-Pierre Chiasson	**Clinique du Nouveau Départ Inc.** Directeur médical (Montréal, Québec) **Expert invité lors d'une assemblée publique**	**30 mai 2002** **Montréal, Québec**
Ward Clapham	**Gendarmerie Royale du Canada** Surintendant (Richmond, Colombie-Britannique)	**14 mai 2002** **Richmond, Colombie-Britannique**
Chantal Cloutier-Vautour	**Services de toxicomanie, Santé régionale** Conseillère auprès des jeunes (Moncton, Nouveau-Brunswick)	**5 juin 2002** **Moncton, Nouveau-Brunswick**
Pierre Cloutier	**À titre personnel**	**31 mai 2002** **Montréal, Québec**
Peter Cohen	**Université d'Amsterdam** Professeur (Amsterdam, Pays-Bas)	**28 mai 2001** **Ottawa, Ontario**
Émile Colas	**À titre personnel** **Expert invité lors d'une assemblée publique**	**30 mai 2002** **Montréal, Canada**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Mark Connolly	**Agence des douanes et du revenu du Canada** Directeur général, Direction de la contrebande et des services de renseignements, Direction générale des douanes (Ottawa, Ontario)	**29 octobre 2001** **Ottawa, Ontario**
John W. Conroy	**À titre personnel** Avocat (R. *c. Malmo-Levine* et R. *c. Caine*)	**11 mars 2002** **Ottawa, Ontario**
Randy Cormier	**Brentwood Recovery Home** Conseiller/chef d'équipe (Windsor, Ontario)	**7 juin 2002** **Windsor, Ontario**
Terry Cormier	**Ministère des Affaires étrangères et du Commerce international** Directeur, Direction du crime international (Ottawa, Ontario)	**18 mars 2002** **Ottawa, Ontario**
Jean-Michel Coste	**Observatoire français des drogues et des toxicomanies** Directeur (Paris, France)	**1er octobre 2001** **Ottawa, Ontario**
Roland Côté	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
Richard Cowan	**À titre personnel**	**7 novembre 2001** **Vancouver, Colombie-Britannique**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Michael Crichton	**Agence des douanes et du revenu du Canada** Chef, Section de la collecte des renseignements, Division du renseignement et des opérations, Direction de la contrebande et des services de renseignements (Ottawa, Ontario)	**29 octobre 2001** **Ottawa, Ontario**
Jean de Lavaltrie	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
France Desjardins	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
Chuck Doucette	**Gendarmerie Royale du Canada** (Vancouver, Colombie-Britannique) **Expert invité lors d'une assemblée publique**	**14 mai 2002** **Richmond, Colombie-Britannique**
Wally Dowhayko	**Gendarmerie royale du Canada** Sergent d'état-major et officier responsable de la section des stupéfiants (Windsor, Ontario)	**7 juin 2002** **Windsor, Ontario**
Caroline Doyer	**Club Compassion de Montréal** Présidente (Montréal, Québec)	**31 mai 2002** **Montréal, Québec**
Toby Druce	**Seaton House** Superviseur des programmes (Toronto, Ontario)	**10 septembre 2001** **Toronto, Ontario**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Françoise Dubois-Arber	**Commission fédérale pour les questions liées aux drogues et Institut universitaire de médecine sociale et préventive** Membre (Berne, Suisse)	**4 février 2002** **Ottawa, Ontario**
Georges Dulex	**Canton de Zürich, Département de la police criminelle** Chef en service (Zürich, Suisse)	**4 février 2002** **Ottawa, Ontario**
Johnny Dupuis	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
Martin Earl	**À titre personnel**	**6 juin 2002** **Windsor, Ontario**
Bill Elliot	**Agence des douanes et du revenu du Canada** Directeur, Division de Windsor-St. Clair (Windsor, Ontario)	**7 juin 2002** **Windsor, Ontario**
Marc Emery	**B.C. Marijuana Party** (Vancouver, Colombie-Britannique) **Expert invité lors d'une assemblée publique**	**14 mai 2002** **Richmond, Colombie-Britannique**
Ron Enns	**À titre personnel**	**6 juin 2002** **Windsor, Ontario**
Patricia Erickson	**Centre de toxicomanie et de la santé mentale** Recherchiste (Toronto, Ontario)	**14 mai 2001** **Ottawa, Ontario**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Julian Fantino	**Service de police de Toronto** Chef de police (Toronto, Ontario)	**10 septembre 2001** **Toronto, Ontario**
Pat Fiacco	**Ville de Regina** Maire (Regina, Saskatchewan)	**13 mai 2002** **Regina, Saskatchewan**
Ross Findlater	**Services aux alcooliques et aux toxicomanes, District de santé de Regina** Deputy Medical Health Officer (Regina, Saskatchewan)	**13 mai 2002** **Regina, Saskatchewan**
Benedikt Fischer	**Université de Toronto** Professeur, Département des sciences de la santé publique (Toronto, Ontario)	**17 septembre 2001** **Ottawa, Ontario**
Jerry Fitzgerald	**Services aux alcooliques et aux toxicomanes, District de santé de Regina** Directeur (Regina, Saskatchewan)	**13 mai 2002** **Regina, Saskatchewan**
Donald Fitzsimmons	**Services aux alcooliques et aux toxicomanes, District de santé de Regina** Coordonnateur pour les jeunes et la famille (Regina, Saskatchewan)	**13 mai 2002** **Regina, Saskatchewan**
Mark Fortier	**À titre personnel**	**13 mai 2002** **Regina, Saskatchewan**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Michel Frenette	**Gendarmerie Royale du Canada** Coordonnateur de la sensibilisation aux drogues (Fredericton, Nouveau-Brunswick) **Expert invité lors d'une assemblée publique**	**5 juin 2002** **Moncton, Nouveau-Brunswick**
Thomas Fulgosi	**Seaton House** Chef d'équipe (Toronto, Ontario)	**10 septembre 2001** **Toronto, Ontario**
Nick Gallant	**À titre personnel**	**5 juin 2002** **Moncton, Nouveau-Brunswick**
Paul E. Garfinkel	**Centre de toxicomanie et de santé mentale** Président et directeur général (Toronto, Ontario)	**7 juin 2002** **Windsor, Ontario**
Serge Gascon	**Service de police de la ville de Montréal** Directeur adjoint (Montréal, Québec)	**31 mai 2002** **Montréal, Québec**
Ryan Genie	**À titre personnel**	**13 mai 2002** **Regina, Saskatchewan**
Michel Germain	**Comité permanent de lutte à la toxicomanie** Directeur général (Montréal, Québec)	**31 mai 2002** **Montréal, Québec**
Rob Gillespie	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
John P. Gordon	**À titre personnel**	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Hélène Goulet	**Santé Canada** Directrice générale, Lutte contre le tabagisme, Direction générale de la santé environnementale et de la sécurité des consommateurs (Ottawa, Ontario)	**10 juin 2002** **Ottawa, Ontario**
Caylie Graham	**À titre personnel**	**13 mai 2002** **Regina, Saskatchewan**
Serge Granger	**Université du Québec à Montréal** Historien (Montréal, Québec)	**31 mai 2002** **Montréal, Québec**
Brian Grant	**Service correctionnel du Canada** Directeur, Centre de recherche en toxicomanie (Montague, Île-du-Prince-Édouard)	**10 juin 2002** **Ottawa, Ontario**
David Griffin	**Association canadienne des policiers et des policières** Agent exécutif (Ottawa, Ontario)	**28 mai 2001** **Ottawa, Ontario**
Peter Grin	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**
Derril W. Gudlaugson	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
André-Bernard Guévin	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
Cathleen Guthrie	**À titre personnel**	**13 mai 2002** **Regina, Saskatchewan**
Henry Haddad	**Association médicale canadienne** Président (Ottawa, Ontario)	**11 mars 2002** **Ottawa, Ontario**
Susan Hague	**Agence des douanes et du revenu du Canada** Conseillère de programme senior, Section des opérations anticontrebande, Direction de la contrebande et des services de renseignements (Ottawa, Ontario)	**29 octobre 2001** **Ottawa, Ontario**
Nichola Hall	**Grief to Action** Présidente (Vancouver, Colombie-Britannique)	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Ross Hall	**Grief to Action** (Vancouver, Colombie-Britannique)	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Peter Hamel	**Club Compassion de Montréal** Directeur exécutif (Montréal, Québec)	**31 mai 2002** **Montréal, Québec**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Tony Hammer	**À titre personnel**	**6 juin 2002** **Windsor, Ontario**
Timothy Hampton	**NORML Saskatchewan** Président, Organisation nationale pour la réforme des lois sur la marijuana (Watrous, Saskatchewan) **Expert invité lors d'une assemblée publique**	**13 mai 2002** **Regina, Saskatchewan**
Michael C. Hansen	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**
Andy Hathaway	**Centre de toxicomanie et de la santé mentale** Recherchiste (Toronto, Ontario)	**14 mai 2001** **Ottawa, Ontario**
Glen Hayden	**Association canadienne des policiers et des policières** Sergent et détective, Section de contrôle des stupéfiants, Service de police d'Edmonton (Ottawa, Ontario)	**28 mai 2001** **Ottawa, Ontario**
Kenneth E. Hayes Jr.	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**
Kash Heed	**Service de police de Vancouver** Service des drogues (Vancouver, Colombie-Britannique)	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Sean Hunt	**À titre individuel**	**10 septembre 2001** **Toronto, Ontario**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Thomas E. Hunter	**À titre personnel**	**5 juin 2002** **Moncton, Nouveau-Brunswick**
Alexis Jabarit	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
Edward Jackson	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
Gary E. Johnson	**État de Nouveau-Mexique** Gouverneur (Albuquerque, Nouveau-Mexique – États-Unis d'Amérique)	**2 novembre 2001** **Ottawa, Ontario**
Cal Johnston	**Service de police de Regina** Chef de police (Regina, Saskatchewan)	**13 mai 2002** **Regina, Saskatchewan**
Hélène Jutras	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
Harold Kalant	**Université de Toronto** Professeur émérite (Toronto, Ontario)	**11 juin 2001** **Ottawa, Ontario**
Sean Karl	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Robert Keizer	**Ministère de la Santé, du Bien-être et des Sports des Pays-Bas** Conseiller en matière de politiques sur les drogues (La Haye, Pays-Bas)	**19 novembre 2001** **Ottawa, Ontario**
Jim Kelly	**Richmond Alcohol and Drug Action Team (RADAT)** Directeur (Richmond, Colombie-Britannique)	**14 mai 2002** **Richmond, Colombie-Britannique**
Perry Kendall	**À titre personnel** Agent de santé (Victoria, Colombie-Britannique)	**17 septembre 2001** **Ottawa, Ontario**
Paul E. Kennedy	**Solliciteur général de Canada** Sous-solliciteur général adjoint principal, Secteur de la police et de la sécurité (Ottawa, Ontario)	**10 juin 2002** **Ottawa, Ontario**
Steven Kent	**Ville de Mount Pearl** Maire suppléant (Mount Pearl, Terre-Neuve-et-Labrador)	**4 juin 2002** **Mount Pearl, Terre-Neuve-et-Labrador**
Barry King	**Association canadienne des chefs de police** Président sortant du Comité sur la toxicomanie et chef du Service de police de Brockville (Ottawa, Ontario)	**11 mars 2002** **Ottawa, Ontario**
Michel Kokoreff	**Université de Lille** (Lille, France)	**1er octobre 2001** **Ottawa, Ontario**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Dirk J. Korf	**Université d'Amsterdam** Professeur (Amsterdam, Pays-Bas)	**19 novembre 2001** **Ottawa, Ontario**
Michele Kubby	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**
Alain Labrousse	**Observatoire français des drogues et des toxicomanies** Chargé de mission (Paris, France)	**28 mai 2001** **Ottawa, Ontario**
C. Gwendolyn Landolt	**REAL Women of Canada** Vice-présidente nationale (Ottawa, Ontario) **Expert invité lors d'une assemblée publique**	**6 juin 2002** **Windsor, Ontario**
Michel Landry	**Centre Dollard-Cormier** Directeur des services professionnels et de la recherche (Montréal, Québec)	**10 décembre 2001** **Ottawa, Ontario**
Julie Langlois	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
Dana Larsen	**Cannabis Culture** (Vancouver, Colombie-Britannique) **Expert invité lors d'une assemblée publique**	**7 novembre 2001 et 14 mai 2002** **Vancouver et Richmond, Colombie-Britannique**
Pierre Lauzon	**À titre personnel** **Expert invité lors d'une assemblée publique**	**30 mai 2002** **Montréal, Québec**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Marc-André Lavoie	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
James Leslie	**À titre personnel**	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Robert G. Lesser	**Gendarmerie Royale du Canada** Surintendant principal (Ottawa, Ontario) **Association canadienne des chefs de police** Vice-président du Comité sur la toxicomanie et surintendant principal auprès de la GRC (Ottawa, Ontario)	**29 octobre 2001 et 11 mars 2002** **Ottawa, Ontario**
Mason Loh	**À titre personnel**	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Dennis Long	**Breakaway** Directeur général (Toronto, Ontario)	**10 septembre 2001** **Toronto, Ontario**
Blair T. Longley	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
Cynthia Low	**À titre personnel**	**7 novembre 2001** **Vancouver, Colombie-Britannique**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Phillippe Lucas	**Vancouver Island Compassion Society** Directeur (Victoria, Colombie-Britannique)	**14 mai 2002** **Richmond, Colombie-Britannique**
Gillian Lynch	**Santé Canada** Directrice générale, Stratégie antidrogue et substances contrôlées (Ottawa, Ontario)	**10 juin 2002** **Ottawa, Ontario**
Mary Lynch	**Université Dalhousie** Directrice, Consortium canadien pour l'investigation des cannabinoïdes (Halifax, Nouvelle-Écosse)	**11 juin 2001** **Ottawa, Ontario**
Sandy MacDonald	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**
Edward J. MacEachern	**Gendarmerie royale du Canada** Sergent (Fredericton, Nouveau-Brunswick)	**5 juin 2002** **Moncton, Nouveau-Brunswick**
David MacFarnam	**À titre personnel**	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Chris MacLean	**À titre personnel**	**5 juin 2002** **Moncton, Nouveau-Brunswick**
Donald MacPherson	**Ville de Vancouver** Coordonnateur de la politique en matière de drogues (Vancouver, Colombie-Britannique)	**7 novembre 2001** **Vancouver, Colombie-Britannique**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Nicole Maestracci	**Mission interministérielle de lutte à la drogue et à la toxicomanie** Présidente (Paris, France)	**1er octobre 2001** **Ottawa, Ontario**
Achille Maillet	**Services de toxicomanie, Santé régionale** Directeur (Moncton, Nouveau-Brunswick)	**5 juin 2002** **Moncton, Nouveau-Brunswick**
David Malmo-Levine	**À titre personnel**	**7 novembre 2001 et 14 mai 2002** **Vancouver et Richmond, Colombie-Britannique**
Colin R. Mangham	**Prevention Source B.C.** Directeur (Vancouver, Colombie-Britannique)	**17 septembre 2001** **Ottawa, Ontario**
Bill Marra	**Fédération canadienne des municipalités** Président du Comité permanent sur la sécurité communautaire et la lutte contre le crime et conseiller municipal de la Ville de Windsor (Ottawa, Ontario)	**11 mars 2002** **Ottawa, Ontario**
Richard Mathias	**Université de la Colombie-Britannique** Professeur, Département de santé et d'épidémiologie (Vancouver, Colombie-Britannique)	**17 septembre 2001** **Ottawa, Ontario**
Pierre Matteau	**À titre personnel**	**30 mai 2002** **Montréal, Québec**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
William B. McAllister	**Université de la Virginie** Professeur (Charlottesville, Virginie, États-Unis d'Amérique)	**18 mars 2002** **Ottawa, Ontario**
Michael McCoy	**Touchtone Family Association** (Richmond, Colombie-Britannique) **Expert invité lors d'une assemblée publique**	**14 mai 2002** **Richmond, Colombie-Britannique**
John McIntyre	**Civil Liberties Association de la Colombie-Britannique** Membre du conseil d'administration (Vancouver, Colombie-Britannique)	**14 mai 2002** **Richmond, Colombie-Britannique**
W. Joe McKeown	**Ville de Regina** Conseiller municipal (Regina, Saskatchewan) **Expert invité lors d'une assemblée publique**	**13 mai 2002** **Regina, Saskatchewan**
William A. McKim	**Memorial University of Newfoundland** Chef de section par intérim, Département de psychologie (Saint-Jean, Terre-Neuve-et-Labrador) **Expert invité lors d'une assemblée publique**	**4 juin 2002** **Mount Pearl, Terre-Neuve-et-Labrador**
Ken McLennan	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**
Wanda McPherson	**Springboard** Coordonnatrice de la déjudiciarisation (Toronto, Ontario)	**10 septembre 2001** **Toronto, Ontario**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Timothy Meehan	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**
Céline Mercier	**Université McGill** Professeure agrégée, Département de psychiatrie (Montréal, Québec)	**10 décembre 2001** **Ottawa, Ontario**
Croft Michaelson	**Justice Canada** Directeur et avocat général principal, Section de l'élaboration des politiques stratégiques en matière en poursuites (Ottawa, Ontario)	**10 juin 2002** **Ottawa, Ontario**
Dann Michols	**Santé Canada** Sous-ministre adjoint, Direction générale de la santé environnementale et de la sécurité des consommateurs (Ottawa, Ontario)	**10 juin 2002** **Ottawa, Ontario**
Mike Moldovan	**À titre personnel**	**6 juin 2002** **Windsor, Ontario**
John P. Morgan	**City of New York Medical School** Professeur de pharmacologie (Ville de New York, New York, États-Unis d'Amérique)	**11 juin 2001** **Ottawa, Ontario**
Tracy Mortensen	**À titre personnel**	**6 juin 2002** **Windsor, Ontario**
David Mossop	**Community Legal Assistance Society** (Vancouver, Colombie-Britannique)	**7 novembre 2001** **Vancouver, Colombie-Britannique**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Ethan Nadelman	**Lindesmith Centre** Directeur exécutif (Ville de New York, New York, États-Unis d'Amérique)	**2 novembre 2001** **Ottawa, Ontario**
Janet Neves	**Fédération canadienne des municipalités** Analyste politique (Ottawa, Ontario)	**11 mars 2002** **Ottawa, Ontario**
John Noddin	**New Brunswick Home and Schools Association** Ancien président **Expert invité lors d'une assemblée publique**	**5 juin 2002** **Moncton, Nouveau-Brunswick**
Kathryn Noddin	**À titre personnel**	**5 juin 2002** **Moncton, Nouveau-Brunswick**
Dale Orban	**Association canadienne des policiers et policières** Sergent-détective, Section de police de Regina et directeur de l'Association des policiers de Regina (Ottawa, Ontario)	**28 mai 2001** **Ottawa, Ontario**
Albert G. Ormiston	**À titre personnel**	**13 mai 2002** **Regina, Saskatchewan**
Eugene Oscapella	**Fondation canadienne pour une politique sur les drogues** Directeur exécutif (Ottawa, Ontario)	**16 octobre 2000 et 29 octobre 2001** **Ottawa, Ontario**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Philip Owen	**Ville de Vancouver** Maire (Vancouver, Colombie-Britannique)	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Melanie Stephen Patriquen	**Parti marijuana du Canada** (Montréal, Québec)	**5 juin 2002** **Moncton, Nouveau-Brunswick**
Mike Patriquen	**Parti marijuana du Canada** (Montréal, Québec) **Expert invité lors d'une assemblée publique**	**5 juin 2002** **Moncton, Nouveau-Brunswick**
Caroline Pelchat	**Gendarmerie Royale du Canada** Recherchiste, Service de la sensibilisation aux drogues (Ottawa, Ontario)	**29 octobre 2001** **Ottawa, Ontario**
Michel Pelletier	**Gendarmerie Royale du Canada** Sergent d'état-major, Coordonnateur national du service de la sensibilisation aux drogues (Ottawa, Ontario)	**29 octobre 2001** **Ottawa, Ontario**
Michel Perron	**Centre canadien de lutte contre l'alcoolisme et les toxicomanies** Directeur exécutif (Ottawa, Ontario)	**10 juin 2002** **Ottawa, Ontario**
Martin Petit	**CACTUS** Travailleur de milieu (Montréal, Québec)	**31 mai 2002** **Montréal, Québec**
Robert Pike	**Penitentiary Addictions Group** Agent de classement (Saint-Jean, Terre-Neuve-et-Labrador)	**4 juin 2002** **Mount Pearl, Terre-Neuve-et-Labrador**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Jim Power	**Gendarmerie Royale du Canada** Sergent (Clarenville, Terre-Neuve-et-Labrador) **Expert invité lors d'une assemblée publique**	**3 juin 2002** **Mount Pearl, Terre-Neuve-et-Labrador**
Diane Power-Jeans	**Janeway Community Mental Health Division, HCC St. John's** Travailleuse sociale (Saint-Jean, Terre-Neuve-et-Labrador)	**4 juin 2002** **Mount Pearl, Terre-Neuve-et-Labrador**
Fred Pritchard	**Marijuana Compassion Club of Windsor** Fondateur et administrateur (Windsor, Ontario) **Expert invité lors d'une assemblée publique**	**6 juin 2002** **Windsor, Ontario**
Norman Qworden	**À titre personnel**	**6 juin 2002** **Windsor, Ontario**
Alan Randell	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**
Eleanor Randell	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**
Shauna Raycraft	**À titre personnel**	**13 mai 2002** **Regina, Saskatchewan**
Jürgen Rehm	**Université de Zurich** Professeur (Zurich, Suisse)	**14 mai 2001** **Ottawa, Ontario**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Rick Reimer	**À titre personnel**	**31 mai 2002** **Montréal, Québec**
Dave Roberts	**Service de police de Windsor** Inspecteur, Division des enquêtes (Windsor, Ontario)	**7 juin 2002** **Windsor, Ontario**
Gerald Royce	**À titre personnel**	**3 juin 2002** **Mount Pearl, Terre-Neuve-et-Labrador**
Jerome Sabourin	**À titre personnel**	**5 juin 2002** **Moncton, Nouveau-Brunswick**
Greg Schweitzer	**À titre personnel**	**6 juin 2002** **Windsor, Ontario**
Darlene Simpson	**House de Sophrosyne** Directrice du programme (Windsor, Ontario)	**7 juin 2002** **Windsor, Ontario**
Eric Single	**Université de Toronto** Professeur, Département de la santé publique (Toronto, Ontario)	**14 mai 2001** **Ottawa, Ontario**
Leon Smith	**À titre personnel**	**14 mai 2002** **Richmond, Colombie-Britannique**
Patrick Smith	**Centre de toxicomanie et de santé mentale** Vice-président, programmes de clinique (Toronto, Ontario)	**7 juin 2002** **Windsor, Ontario**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Ted Smith	**À titre personnel**	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Raf Souccar	**Gendarmerie royale du Canada** Surintendant de police en chef (Ottawa, Ontario)	**10 juin 2002** **Ottawa, Ontario**
Rob Spring	**À titre personnel**	**6 juin 2002** **Windsor, Ontario**
Randall St. Jacques	**À titre personnel**	**6 juin 2002** **Windsor, Ontario**
Margaret Stanowski	**Springboard** Directrice générale (Toronto, Ontario)	**10 septembre 2001** **Toronto, Ontario**
Paul St-Denis	**Justice Canada** Avocat-conseil, Section de la politique en matière de droit pénal (Ottawa, Ontario)	**10 juin 2002** **Ottawa, Ontario**
Diane Steber Büchli	**Bureau fédéral de santé publique de la Suisse** Chef de service, Unité internationale des affaires de drogues (Berne, Suisse)	**4 février 2002** **Ottawa, Ontario**
Art Steinmann	**Alcohol-Drug Education Service** Directeur exécutif (Vancouver, Colombie-Britannique)	**7 novembre 2001** **Vancouver, Colombie-Britannique**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Marc-Boris St-Maurice	**Parti Marijuana** Chef (Montréal, Québec) **Expert invité lors d'une assemblée publique**	**30 mai 2002 et 31 mai 2002** **Montréal, Québec**
Ron Taverner	**Service de police de Toronto** Sergent et surintendant (Toronto, Ontario)	**7 juin 2002** **Toronto, Ontario**
Rosaire Théorêt	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
Rick Tipple	**À titre personnel**	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Lilian To	**À titre personnel**	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Ross Toller	**Service correctionnel du Canada** Sous-commissaire, Administration régionale – Prairies (Ottawa, Ontario)	**10 juin 2002** **Ottawa, Ontario**
Chris Trenholm	**À titre personnel**	**5 juin 2002** **Moncton, Nouveau-Brunswick**
John Turmel	**À titre personnel**	**30 mai 2002** **Montréal, Québec**
Ray Turmel	**À titre personnel**	**30 mai 2002** **Montréal, Québec**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Selene Tracy Tyndale	**Groupe de recherche d'intérêt public de l'Ontario** Bénévole (Windsor, Ontario) **Expert invité lors d'une assemblée publique**	**6 juin 2002** **Windsor, Ontario**
Mark Tyndall	**Centre d'excellence en VIH/SIDA – Région de la Colombie-Britannique** (Vancouver, Colombie-Britannique)	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Ambros Uchtenhagen	**Institut de recherche sur les addictions** Professeur (retraité) (Zürich, Suisse)	**4 février 2002** **Ottawa, Ontario**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Steven Van Hoogstraten	**Ministère de la Justice des Pays-Bas** Directeur des Affaires internationales criminelles et des politiques sur les drogues (La Haye, Pays-Bas)	**19 novembre 2001** **Ottawa, Ontario**
Anne Vogel	**Clinique Gilwest** Directrice (Richmond, Colombie-Britannique)	**14 mai 2002** **Richmond, Colombie-Britannique**
John Walsh	**Ville de Mount Pearl** Conseiller municipal (Mount Pearl, Terre-Neuve-et-Labrador) **Expert invité lors d'une assemblée publique**	**3 juin 2002** **Mount Pearl, Terre-Neuve-et-Labrador**
Chuck Walter	**Gendarmerie royale du Canada** Inspecteur et officier responsable, Section des politiques des systèmes opérationnels, Sous-direction de la police contractuelle nationale (Ottawa, Ontario)	**10 juin 2002** **Ottawa, Ontario**
Thia Walter	**À titre personnel**	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Mark A. Ware	**Université McGill** Professeur adjoint (Montréal, Québec)	**31 mai 2002** **Montréal, Québec**
David Weinberg	**À titre personnel**	**5 juin 2002** **Moncton, Nouveau-Brunswick**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Yves Wermelinger	**À titre personnel**	**5 juin 2002** **Moncton, Nouveau-Brunswick**
Anna Marie White	**Focus on the Family** Analyste des politiques (Vancouver, Colombie-Britannique)	**14 mai 2002** **Richmond, Colombie-Britannique**
Dean Wilson	**Vancouver Area Network of Drug Users (VANDU)** Directeur général (Vancouver, Colombie-Britannique)	**7 novembre 2001** **Vancouver, Colombie-Britannique**
Cory Wint	**Inner Visions Recovery Society** (Vancouver, Colombie-Britannique) **Expert invité lors d'une assemblée publique**	**14 mai 2002** **Richmond, Colombie-Britannique**
Brad Wolbaum	**À titre personnel**	**13 mai 2002** **Regina, Saskatchewan**
Scott Wolbaum	**À titre personnel**	**13 mai 2002** **Regina, Saskatchewan**
Danny Woods	**Service de police de Windsor** Sergent d'état-major, Sous-direction des drogues (Windsor, Ontario)	**7 juin 2002** **Windsor, Ontario**
Alan Young	**À titre personnel** Professeur agrégé Osgoode Hall Law School (Toronto, Ontario)	**10 septembre 2001** **Toronto, Ontario**

NOM	ORGANISATION	DATE ET LIEU DE COMPARUTION
Mark Zoccolillo	**Université McGill** Professeur, Département de psychiatrie (Montréal, Québec)	**16 octobre 2000** **Ottawa, Ontario**

ANNEXE III

RAPPORTS DE RECHERCHE *

A- RAPPORTS DE RECHERCHE PRÉPARÉS PAR LA DIRECTION DE LA RECHERCHE PARLEMENTAIRE DE LA BIBLIOTHÈQUE DU PARLEMENT

AUTEURS	TITRE	DATE DE PARUTION
Lyne Casavant Chantal Collin	**La consommation de drogues illicites et la criminalité : une relation complexe**	Août 2001
Chantal Collin	**Politique nationale en matière de drogues : France**	Août 2001
Chantal Collin	**Politique nationale en matière de drogues : Suisse**	Janvier 2002
Benjamin Dolin	**Politique nationale en matière de drogues : États-Unis d'Amérique**	Juillet 2001
Benjamin Dolin	**Politique nationale en matière de drogues : Pays-Bas**	Août 2001
Daniel Dupras	**Les obligations internationales du Canada en vertu des principales conventions internationales sur le contrôle des drogues**	Octobre 1998
David Goetz	**La prohibition des drogues et la Constitution**	Mars 2001
Anthony Jackson	**Le coût de la consommation de drogues et la politique sur les drogues**	Avril 2002

* Tous les rapports de recherche cités dans cette annexe ont été produits à la demande du Comité spécial du Sénat sur les drogues illicites et sont disponibles à l'adresse suivante : www.parl.gc.ca/drogues-illicites.asp

AUTEURS	TITRE	DATE DE PARUTION
Diane Leduc, Nancy Miller Chenier, Sonya Norris	**Inventaire de la recherche fédérale sur les drogues illicites et les questions connexes**	Octobre 2001
Diane Leduc, Nancy Miller Chenier, Sonya Norris	**Inventaire de la recherche provinciale et territoriale sur les drogues illicites et les questions connexes**	Mai 2002
Gérald Lafrenière	**Les pouvoirs de la police et les infractions liées à la drogue**	Mars 2001
Gérald Lafrenière	**Politique nationale en matière de drogues : Royaume-Uni**	Juillet 2001
Gérald Lafrenière	**Politique nationale en matière de drogues : Suède**	Avril 2002
Gérald Lafrenière, Emmanuel Préville	**Affaires déclarées, condamnations, peines d'emprisonnement et déterminations de peines en rapport avec les drogues illicites au Canada**	Mai 2002
Gérald Lafrenière, Leah Spicer	**Les drogues illicites au Canada – Tendances 1980-2001 : Examen et analyse des données sur l'application des lois**	Juin 2002
Robin MacKay	**Politique nationale en matière de drogues : Australie**	Décembre 2001
Jay Sinha	**L'historique et l'évolution des principales conventions internationales de contrôle des stupéfiants**	Février 2001
Leah Spicer	**Utilisations historiques et culturelles du cannabis et le « débat sur la marijuana » au Canada**	Avril 2002

B- RAPPORTS DE RECHERCHE SUR LES PRINCIPES DIRECTEURS

AUTEURS	TITRE	DATE DE PARUTION
Thomas De Koninck **Université Laval**	**Le rôle des savoirs et de la culture dans la politique publique sur les drogues illicites**	Juin 2002
Roderick A. Macdonald **Université McGill**	**La gestion publique des humains**	Mai 2001
Jean-François Malherbe **Université de Sherbrooke**	**Contribution de l'éthique à la définition de principes directeurs pour une politique publique sur les drogues illicites**	Mai 2002
Alvaro P. Pires **Université d'Ottawa**	**La politique législative et les crimes à « double face » : Éléments pour une théorie pluridimensionnelle de la loi criminelle**	Juin 2002

C- AUTRES RAPPORTS DE RECHERCHE

AUTEURS	TITRE	DATE DE PARUTION
François Dubois **Bureau du sénateur Pierre Claude Nolin**	**Le Parlement fédéral et l'évolution de la législation canadienne sur les drogues illicites**	Juin 2002
Léger Marketing **Montréal**	**Étude exploratoire auprès des Canadiens sur l'usage du cannabis**	Juin 2002
Diane Riley **Université de Toronto**	**La politique canadienne de contrôle des drogues : aperçu et commentaire**	Novembre 1998
Barbara B. Wheelock **Bureau de la sénatrice Eileen Rossiter**	**Effets physiologiques et psychologiques du cannabis : examen des conclusions des travaux de recherche**	Mai 2002

ANNEXE IV

L'évolution de la législation canadienne sur les drogues (1908-1996) : Infractions, peines, pouvoirs policiers et procédure criminelle*

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
1908 – **Loi sur l'opium**	***Trafic*** • **importation d'opium à des fins autres que médicales et sans autorisation du ministre des Douanes** • **fabrication, vente ou <u>possession en vue de la vente</u>, d'opium brut ou préparé** • **fabrication, vente ou <u>possession en vue de la vente</u>, d'opium préparé à l'usage des fumeurs**	**Mise en accusation** • **Emprisonnement maximal de 3 ans; et / ou** • **Amende minimale de 50 $ pouvant aller jusqu'à un maximum de 1 000 $**	

* Ce tableau provient de l'étude réalisée par François Dubois intitulée *Le Parlement fédéral et l'évolution de la législation canadienne sur les drogues illicites*. Elle est disponible en ligne à: www.parl.gc.ca/drogues-illicites.asp

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
1911 – **Loi sur l'opium et les narcotiques**	*Trafic* • **Importation, transport à l'intérieur du Canada, fabrication, vente ou offre en vente, <u>sans excuse légitime</u>, d'une drogue à des fins autres que thérapeutiques ou scientifiques** • **Exportation, <u>sans excuse légitime</u>, dans un pays qui interdit l'importation d'une drogue**	**Procédure sommaire** • **Emprisonnement maximal d'un an; et / ou** • **Amende maximale de 500 $** **Procédure sommaire** • **Emprisonnement maximal de 6 mois; et / ou** • **Amende maximale de 500 $**	*Pouvoirs policiers* **Mandats de perquisition** • **Mandat de perquisition autorisant, s'il existe des motifs raisonnables :** ▪ **la fouille des lieux suivants : maison d'habitation, magasin, boutique, entrepôt, jardin ou navire; et** ▪ **la saisie de toute drogue qui s'y trouve ainsi que des contenants dans lesquels elle a été trouvée.** *Procédure criminelle* **Destruction des drogues saisies** • **Ordonnance permettant la destruction des drogues ainsi que des contenants dans lesquels elles ont été trouvées après la condamnation de l'accusé** • **Ordonnance prévoyant la restitution des drogues saisies si l'accusé est acquitté. Si elles ne sont pas réclamées, elles doivent être détruites au plus tard dans les trois mois suivant l'acquittement**
	Possession • **Simple possession d'une drogue, <u>sans excuse légitime</u>, à des fins autres que thérapeutiques ou scientifiques**	**Procédure sommaire** • **Emprisonnement maximal d'un an; et / ou** • **Amende maximale de 500 $**	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	• **Possession d'opium préparé pour fumeurs ou usage d'une telle substance**	**Procédure sommaire** • **Emprisonnement maximal de 3 mois; et / ou** • **Amende maximale de 50 $**	**Renversement du fardeau de la preuve au détriment de l'accusé** • **Lors d'une poursuite pour trafic ou simple possession de drogues, l'accusé doit prouver, s'il veut être acquitté :** ▪ **l'existence d'une excuse légitime; ou** ▪ **l'utilisation de telles substances à des fins thérapeutiques ou scientifiques**
	• **Se trouver dans un lieu, <u>sans excuse légitime</u>, où l'on fume de l'opium**	**Procédure sommaire** • **Emprisonnement maximal d'un mois; et / ou** • **Amende maximale de 100 $**	**Bref de *certiorari*** • **Élimination du recours à un bref de *certiorari***
	Commerce légal de stupéfiants **(Médecin)** • **Prescription de drogues pour des fins autres que thérapeutiques ou qui ne sont pas requises pour le traitement d'une maladie**	**Procédure sommaire** • **Emprisonnement maximal de 3 mois; et / ou** • **Amende maximale de 200 $**	**Récompense** • **Utilisation d'une partie du montant d'une amende payée par un contrevenant afin de récompenser la personne qui a porté plainte contre lui**

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	(Pharmacien)		
	• **Vente de drogues à des fins thérapeutiques sans prescription (écrite ou téléphonique) par un médecin**	**Procédure sommaire** • **Emprisonnement maximal de 3 mois; et / ou** • **Amende maximale de 200 $**	
	• **Refus de tenir un registre relativement aux achats ou ventes de drogues, à la fabrication de médicaments contenant de telles substances et au renouvellement de prescriptions émises par un médecin**	**Procédure sommaire** • **Emprisonnement maximal de 3 mois; et / ou** • **Amende maximale de 200 $**	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
1920 – **Modifications à la Loi de 1911**	*Trafic*		
	• **Exportation ou importation, fabrication, transport à l'intérieur du Canada, vente et distribution d'une drogue sans permis, ou importation de celle-ci dans un port non désigné par les autorités fédérales**	**Procédure sommaire** • **Emprisonnement maximal d'un an; et / ou** • **Amende minimale de 200 $ pouvant aller jusqu'à un maximum de 1 000 $**	
	• **Exportation ou importation, fabrication, transport à l'intérieur du Canada, vente et distribution d'opium brut ou préparé sans permis**		
	Possession		
	• **Simple possession de drogues, sans permis, à des fins autres que thérapeutiques ou scientifiques**	**Procédure sommaire** • **Emprisonnement maximal d'un an; et / ou** • **Amende minimale de 200 $ pouvant aller jusqu'à un maximum de 1 000 $**	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	Commerce légal de stupéfiants		
	(Entreprises)		
	• **Refus de tenir un registre sur les activités d'importation, d'exportation, de fabrication, de vente et de distribution de drogues dûment autorisées par les autorités fédérales**	**Procédure sommaire** • **Emprisonnement maximal d'un an; et / ou** • **Amende minimale de 200 $ pouvant aller jusqu'à un maximum de 1 000 $**	
	(Médecin)		
	• **Refus de fournir les renseignements demandés par les autorités fédérales relativement à l'achat, la fabrication ou la prescription de médicaments contenant des drogues**	**Procédure sommaire** • **Emprisonnement maximal d'un an; et / ou** • **Amende minimale de 200 $ pouvant aller jusqu'à un maximum de 1 000 $**	
	(Pharmacien)		
	• **Vente de drogues à des fins médicales <u>sans prescription écrite et signée</u> par un médecin**	**Procédure sommaire** • **Emprisonnement maximal d'un an; et / ou** • **Amende minimale de 500 $ pouvant aller jusqu'à un maximum de 1 000 $**	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	• Vente ou administration d'un produit contenant des quantités de drogues excédant les limites prescrites par la Loi et sans un étiquetage approprié à un enfant âgé de moins de 2 ans	**Procédure sommaire** • Emprisonnement maximal d'un an; et / ou • Amende minimale de 200 $ pouvant aller jusqu'à un maximum de 1 000 $	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
1921 – **Modifications à la Loi de 1911**	*Trafic* • Activités illégales telles que définies dans la Loi de 1920	Mise en accusation • Emprisonnement maximal de 7 ans Procédure sommaire • Emprisonnement maximal de 18 mois auquel peut être rajoutée une période additionnelle de 12 mois pour défaut de paiement d'une amende; et / ou • Amende minimale de 200 $ pouvant aller jusqu'à un maximum de 1 000 $	*Procédure criminelle* Confiscation ou restitution des drogues saisies • Ordonnance prévoyant la confiscation au profit du ministre de la Santé des drogues saisies ainsi que des contenants dans lesquels elles ont été trouvées après la condamnation de l'accusé • Ordonnance prévoyant la restitution des drogues saisies si l'accusé est acquitté. Si elles ne sont pas réclamées, elles doivent être confisquées au profit du ministre de la Santé, au plus tard dans les trois mois suivant l'acquittement, afin que ce dernier puisse en disposer à sa guise
	• Vente, don ou distribution de drogues à un mineur sans permis	Mise en accusation • Emprisonnement maximal de 7 ans	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	Possession • Simple possession	Mise en accusation • Emprisonnement maximal de 7 ans Procédure sommaire • Emprisonnement maximal de 18 mois auquel peut être rajoutée une période additionnelle de 12 mois pour défaut de paiement d'une amende; et / ou • Amende minimale de 200 $ pouvant aller jusqu'à un maximum de 1 000 $	Renversement du fardeau de la preuve • Toute personne qui <u>possède ou occupe un endroit</u> (logement, magasin, boutique, entrepôt, jardin ou navire) où une drogue est trouvée est réputée posséder illégalement une telle substance si elle est incapable de prouver qu'elle : ▪ était à cet endroit sans son consentement; ou ▪ ne savait pas qu'une drogue s'y trouvait. Lorsqu'une personne est accusée d'avoir exporté, importé, fabriqué, transporté, vendu, donné ou distribué de <u>l'opium brut ou préparé</u> sans avoir préalablement obtenu un permis délivré par les autorités fédérales, elle doit prouver qu'elle détenait une telle autorisation. Certificat d'un analyste fédéral • Admissibilité du certificat d'un analyste fédéral en preuve relativement à une ou plusieurs drogues saisies par les policiers

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
1922 – **Modifications à la Loi de 1911**	*Trafic* • Activités illégales telles que définies dans la Loi de 1920 <u>à l'exception de la plupart des infractions relatives à l'opium brut ou préparé sans permis</u> • <u>Maintien de l'infraction relative à l'exportation d'opium brut ou préparé</u>	Mise en accusation • Emprisonnement maximal de 7 ans Procédure sommaire • Emprisonnement minimal de 6 mois jusqu'à un maximum de 18 mois; et • Amende minimale de 200 $ pouvant aller jusqu'à un maximum de 1 000 $ (Déportation de tout immigrant après la fin de sa peine)	*Pouvoirs policiers* Mandats de perquisition • Autorisation de mener <u>sans mandat</u> une fouille ou saisie de drogues dans les lieux suivants : magasin, boutique, entrepôt, jardin, et navire • Autorisation de procéder avec <u>un mandat</u> à une perquisition dans une maison d'habitation si le policier qui en fait la demande a des motifs raisonnables de croire que de telles substances s'y trouvent *Procédure criminelle* Renversement du fardeau de la preuve
	• Vente, don ou distribution de drogues à un mineur, sans permis	Mise en accusation • Emprisonnement minimal de 6 mois jusqu'à un maximum de 7 ans • Fouet à la discrétion du juge (Déportation de tout immigrant après la fin de sa peine)	• Abrogation de cette procédure dans le cas des infractions liées à l'opium brut ou préparé, à l'exception des accusations impliquant son exportation • Utilisation de la procédure pour l'infraction de vente, don ou distribution de drogues à un mineur

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	Possession		
	• **Simple possession**	**Mise en accusation** • **Emprisonnement maximal de 7 ans** **Procédure sommaire** • **Emprisonnement minimal de 6 mois jusqu'à un maximum de 18 mois; et** • **Amende minimale de 200 $ pouvant aller jusqu'à un maximum de 1 000 $** **(Déportation de tout immigrant après la fin de sa peine)**	
	• **Possession de pipes, lampes ou tout autre équipement utilisés pour la préparation ou la consommation d'opium, sauf si elle est autorisée par les autorités fédérales**	**Procédure sommaire** • **Emprisonnement maximal d'un mois; et / ou** • **Amende maximale de 100 $**	

Infractions	Peines
Commerce légal de stupéfiants	
(Médecin)	
• **Refus de fournir les renseignements demandés par les autorités fédérales relativement à l'achat, la fabrication ou la prescription de médicaments contenant des drogues**	Procédure sommaire • **Emprisonnement maximal de 18 mois; et / ou** • **Amende minimale de 200 $ pouvant aller jusqu'à un maximum de 1 000 $**
• **Prescription de drogues pour des fins autres que thérapeutiques notamment <u>lorsqu'elles ne sont pas requises pour le traitement d'une maladie</u>**	Procédure sommaire • **Emprisonnement maximal de 18 mois; et / ou** • **Amende maximale de 1 000 $**
(Pharmacien)	
Vente d'une drogue à des fins médicales sans prescription <u>écrite et signée</u> par un médecin	Procédure sommaire • **Emprisonnement maximal de 18 mois; et / ou** • **Amende minimale de 200 $ jusqu'à un maximum de 1 000 $**

<table>
<tr><th>Lois</th><th>Infractions</th><th>Peines</th><th>Pouvoirs policiers – Procédure criminelle</th></tr>
<tr><td>1923 –

Codification législative de la Loi de 1911 et autres modifications</td><td>Trafic

• Exportation ou importation, transport à l'intérieur du Canada, fabrication, vente, <u>don</u> et distribution de drogues sans permis, ou importation de celle-ci dans un port non désigné par les autorités fédérales</td><td>Mise en accusation

• Emprisonnement minimal de 6 mois jusqu'à un maximum de 7 ans; et

• Amende minimale de 200 $ jusqu'à un maximum de 1 000 $

Procédure sommaire

• Aucune modification

(Le tribunal ne peut imposer une peine moindre que le minimum prescrit par la Loi)</td><td rowspan="2">Pouvoirs policiers

Maintien des pouvoirs octroyés aux policiers en 1911 et 1922

Procédure criminelle

Maintien des procédures criminelles adoptées entre 1911 et 1922 à l'exception de :

• l'utilisation d'une partie du montant d'une amende payée par un contrevenant afin de récompenser la personne qui a porté plainte contre lui

Nouvelles procédures criminelles

Droit d'appel

• Retrait du droit d'appel d'un verdict de culpabilité et / ou d'une sentence dans le cas d'une déclaration de <u>culpabilité par procédure sommaire</u> pour les infractions suivantes :

• trafic ou possession de drogue sans permis

• vente, don ou distribution de drogue à un mineur</td></tr>
<tr><td></td><td>• Vente, don ou distribution de stupéfiants à un mineur, sans permis</td><td>Mise en accusation

• Emprisonnement minimal de 6 mois jusqu'à un maximum de 7 ans; et

• Amende minimale de 200 $ jusqu'à un maximum de 1 000 $

(Le tribunal ne peut imposer une peine moindre que le minimum prescrit par la Loi)</td></tr>
</table>

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	Possession		**Renversement du fardeau de la preuve**
	• **Simple possession**	**Mise en accusation** • **Emprisonnement minimal de 6 mois jusqu'à un maximum de 7 ans; et** • **Amende minimale de 200 $ jusqu'à un maximum de 1 000 $** **Procédure sommaire** • **Aucune modification** **(Le tribunal ne peut imposer une peine moindre que le minimum prescrit par la Loi)**	• **Maintien de la procédure pour les infractions de simple possession ou trafic, sans permis** • **Ajout de l'infraction prévoyant que tout médecin ne peut prescrire ou administrer à des fins autres que thérapeutiques une drogue. Ainsi, il doit prouver que cette substance fut utilisée uniquement à des fins médicales s'il veut être acquitté** **Empreinte digitales et casier judiciaire** • **Application des dispositions de la *Loi sur l'identification des criminels* aux personnes condamnées par procédure sommaire**
	• **Possession de pipes, lampes ou tout autre équipement utilisés pour la préparation ou la consommation d'opium, sauf si elle est autorisée par les autorités fédérales**	**Procédure sommaire** • **Emprisonnement maximal de 3 mois; et / ou** • **Amende maximale de 100 $**	**Certificat de l'analyste fédéral** • **Autorisation de déposer en preuve un certificat préparé par un analyste provincial**

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	• **Possession d'opium préparé pour fumeurs ou usage d'une telle substance**	**Procédure sommaire** • **Emprisonnement maximal de 3 mois; et / ou** • **Amende maximale de 100 $**	
	• **Se trouver dans un lieu, sans excuse légitime, où l'on fume de l'opium**	**Procédure sommaire** • **Emprisonnement maximal de 3 mois; et / ou** • **Amende maximale de 100 $**	
	Commerce légal de stupéfiants **(Entreprises)**		
	• **Refus de tenir un registre sur les activités d'importation, d'exportation, de fabrication, de vente et de distribution de drogues dûment autorisées par les autorités fédérales**	**Procédure sommaire** • **Aucune modification**	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	(Médecin)		
	• **Prescription de drogues pour des fins autres que thérapeutiques notamment lorsqu'elles ne sont pas requises pour le traitement d'une maladie**	**Procédure sommaire** • **Aucune modification**	
	(Pharmacien)		
	• **Vente d'une drogue à des fins médicales sans prescription <u>écrite et signée</u> par un médecin ou <u>renouvellement de cette dernière à plusieurs reprises</u>**	**Procédure sommaire** • **Aucune modification**	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
1925 – **Modifications à la Loi de 1923**	*Trafic* • **Exportation ou importation, transport à l'intérieur du Canada, fabrication, don, vente et distribution d'une drogue sans permis, ou importation de celle-ci dans un port non désigné par une autorité fédérale**	**Mise en accusation** • **Aucune modification** **Procédure sommaire** • **Aucune modification**	*Pouvoirs policiers* **Perquisitions** • **Autorisation de saisir <u>sans mandat un véhicule automobile, un bateau, une chaloupe ou tout autre moyen de transport dans lequel une drogue fut trouvée</u>** • **Ajout de la possibilité, pour les policiers, de fouiller toute personne se trouvant sur les lieux d'une perquisition**
	Possession • **Simple possession**	**Mise en accusation** • **Aucune modification** **Procédure sommaire** • **En plus des autres peines prévues par la Loi de 1923, le tribunal peut imposer, à sa discrétion, une peine de travaux forcés**	*Procédure criminelle* **Confiscation des drogues saisies** • **Ordonnance prévoyant la confiscation au profit du ministre de la Santé d'un véhicule automobile, d'un bateau, d'une chaloupe ou tout autre moyen de transport <u>dans lequel la drogue fut trouvée</u>** **Moyens de défense des médecins** • **Élimination du moyen de défense prévoyant qu'un médecin peut plaider qu'il a prescrit une drogue à une personne malade ou toxicomane afin que ce dernier**

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	Commerce légal de stupéfiants (Médecin) • **Prescription de drogues pour des fins autres que thérapeutiques notamment lorsqu'elles ne sont pas requises pour le traitement d'une maladie ou <u>qu'elles visent à traiter un toxicomane qui a développé une dépendance à de telles substances suite à une surconsommation</u>**	**Mise en accusation** • **Emprisonnement minimal de 3 mois jusqu'à un maximum de 5 ans** **Procédure sommaire** • **Emprisonnement maximal de 18 mois; et / ou** • **Amende minimale de 200 $ jusqu'à un maximum de 1 000 $** • **Le tribunal peut imposer, à sa discrétion, une peine de travaux forcés**	**puisse se l'administrer lui-même.** **Ainsi, un médecin ne peut plus utiliser comme défense le fait qu'un patient qui s'administre lui-même un médicament constitue un traitement thérapeutique autorisé par la *Loi sur l'opium et les narcotiques***
	(Pharmacien) **Vente d'une drogue à des fins médicales sans prescription <u>écrite et signée</u> par un médecin et <u>sans en authentifier la signature</u>, ou renouvellement de cette dernière à plusieurs reprises.**	**Procédure sommaire** • **Aucune modification**	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
1929 – **Codification législative de la Loi de 1923 et autres modifications**	*Trafic*		*Pouvoirs policiers*
	• Exportation ou importation, transport à l'intérieur du Canada, fabrication, don, vente et distribution sans permis, importation de celle-ci dans un port non désigné par les autorités fédérales, d'une drogue ou d'une substance dont le propriétaire prétend faussement qu'il s'agit d'un stupéfiant	**Mise en accusation** • Aucune modification **Procédure sommaire** • Aucune modification (En plus des autres peines prévues par la Loi de 1923, le tribunal peut imposer, à sa discrétion, le fouet)	**Mandat de main-forte** • Possibilité d'obtenir un mandat de main-forte dans le cadre d'une opération policière menée en vertu de la *Loi sur l'opium et les narcotiques* Cette nouvelle disposition permettait de contourner l'obligation d'obtenir un mandat pour fouiller ou perquisitionner une maison d'habitation
	• Trafic de drogues par courrier	**Mise en accusation** • Emprisonnement minimal de 6 mois jusqu'à un maximum de 7 ans; et • Amende minimale de 200 $ jusqu'à un maximum de 1 000 $ **Procédure sommaire** • Emprisonnement minimal de 6 mois jusqu'à un maximum de 18 mois; et / ou • Amende minimale de 200 $ jusqu'à un maximum de 1 000 $	**Saisies et confiscations** • Élargissement des pouvoirs de saisie et de confiscation déjà prévus dans la Loi aux pipes, lampes, tout autre équipement ou les différentes pièces de ceux-ci utilisés pour la préparation ou la consommation d'opium • Élargissement des pouvoirs de saisie et de confiscation déjà prévus dans la Loi à l'argent utilisé pour l'achat de drogues

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
		(En plus des autres peines prévues par les Lois de 1923 et 1925, le tribunal peut imposer, à sa discrétion, le fouet)	• Maintien de la possibilité de recourir à la force, si nécessaire, pour réaliser une perquisition. Les policiers peuvent également être assistés dans cette tâche par d'autres personnes
	Possession		• Élargissement du pouvoir de saisir et confisquer un véhicule automobile, un bateau, une chaloupe ou tout autre moyen de transport <u>utilisé par un trafiquant condamné pour une infraction à la Loi peu importe s'il y avait ou non une drogue à l'intérieur</u>
	• Simple possession de drogues (ou d'une substance dont le propriétaire prétend faussement qu'il s'agit d'un stupéfiant) sans permis, à des fins autres que thérapeutiques	Mise en accusation • Aucune modification Procédure sommaire • Aucune modification (En plus des autres peines prévues par les Lois de 1923 et 1925, le tribunal peut imposer, à sa discrétion, le fouet)	*Procédure criminelle* Renversement du fardeau de la preuve
	• Possession de pipes, lampes, tout autre équipement ou <u>les différentes pièces de ceux-ci</u> utilisés pour la préparation ou la consommation d'opium, sauf si elle est autorisée par les autorités fédérales	Procédure sommaire • Emprisonnement maximal de 3 mois; et / ou • Amende maximale de <u>50</u> $	• Dans toute affaire relative au trafic ou à la simple possession illégale d'une drogue ou de d'une substance dont le propriétaire prétend faussement qu'il s'agit d'une drogue, le procureur de la Couronne n'a pas à établir que l'intimé n'avait pas une autorisation dûment émise par les autorités fédérales pour commettre l'un des actes reprochés.

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	• **Possession d'opium préparé pour fumeurs ou usage d'une telle substance**	**Procédure sommaire** • **Emprisonnement maximal de 3 mois; et / ou** • **Amende maximale de <u>50</u> $**	• **Si l'accusé allègue qu'il avait une telle autorisation, le fardeau de la preuve lui revient** **Certificat de l'analyste fédéral** • **Modifications à la procédure prévoyant l'admissibilité en preuve du certificat de l'analyste fédéral (ou provincial) en précisant que, dorénavant, ce document constitue une preuve *prima facie* et péremptoire du statut de la personne qui le donne ou l'émet.**
	• **Obtention de drogues auprès de deux médecins**	**Procédure sommaire** • **Amende maximale de 500 $ à laquelle peut être rajoutée une période d'emprisonnement maximale de 12 mois pour défaut de paiement**	• **Dans ce contexte, la preuve de la nomination de l'analyste ou l'authentification de sa signature n'est pas nécessaire**
	Commerce légal de stupéfiants **(Médecin)** **Prescription de drogues pour des fins autres que thérapeutiques notamment lorsqu'elles ne sont pas requises pour le traitement d'une maladie ou <u>qu'elles visent à traiter un toxicomane qui a développé une dépendance à de telles substances suite à une surconsommation</u>**	**Procédure sommaire** **(Aucune modification)** **(Le tribunal ne peut imposer une peine moindre que celle prescrite par la Loi)**	**Bref de *certiorari*** • **Abrogation de la disposition prévoyant l'élimination du recours à un bref de *certiorari*** **Droit d'appel** • **Élargissement de l'interdiction de porter en appel un verdict de culpabilité et / ou une sentence dans le cas d'une déclaration de <u>culpabilité par procédure sommaire</u> pour l'infraction**

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	(Pharmaciens)		**suivante :**
	• **Vente ou administration d'un produit contenant des quantités de stupéfiants excédant les limites prescrites par la Loi et sans un étiquetage approprié à un enfant âgé de moins de 2 ans**	**Procédure sommaire** **(Première infraction)** • **Amende maximale de 100 $** **(Infractions subséquentes)** • **Emprisonnement maximal de 3 mois; et / ou** • **Amende maximale de 100 $**	▪ **possession ou trafic d'une substance <u>qui s'apparente à une drogue</u>**
	• **Refus de tenir un registre relativement aux achats ou ventes de drogues, à la fabrication de médicaments contenant de telles substances et au renouvellement de prescriptions émises par un médecin**	**Procédure sommaire** • **Emprisonnement maximal de <u>18 mois</u>; et / ou** • **Amende minimale de 200 $ pouvant aller jusqu'à un maximum de 1 000 $**	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
1932 – **Modifications à la Loi de 1929**	*Aucune modification*	*Aucune modification*	*Procédure criminelle* **Droit d'appel** • **Élargissement important de l'interdiction de porter en appel un verdit de culpabilité et / ou une sentence dans le cas d'une déclaration de <u>culpabilité par procédure sommaire</u> pour les infractions suivantes :** ▪ **prescription de drogues pour des fins autres que médicales notamment lorsqu'elles ne sont pas requises pour le traitement d'une maladie ou qu'elles visent à traiter un toxicomane qui a développé une dépendance à de telles substances suite à une surconsommation (médecins);** ▪ **refus de fournir les renseignements demandés par les autorités fédérales relativement à l'achat, la fabrication ou la prescription de médicaments contenant des drogues (médecins);** ▪ **obtention de drogues auprès de deux médecins;**

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
			▪ vente ou administration d'un produit contenant des quantités de stupéfiants excédant les limites prescrites par la Loi et sans un étiquetage approprié à un enfant âgé de moins de 2 ans (pharmaciens); ▪ refus de tenir un registre relativement aux achats ou ventes de drogues, à la fabrication de médicaments contenants de telles substances et au renouvellement de prescriptions émises par un médecin (pharmaciens); ▪ possession illégale de pipes, lampes, tout autre équipement ou <u>les différentes pièces de ceux-ci</u> utilisés pour la préparation ou la consommation d'opium; et ▪ trafic de drogues par courrier

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
1938 – **Modifications à la Loi de 1929**	*Trafic* • **Culture du pavot somnifère ou du cannabis sativa sans permis**	**Mise en accusation** • **Emprisonnement minimal de 6 mois pouvant aller jusqu'à 7 ans** • **Amende minimale de 200 $ pouvant aller jusqu'à un maximum de 1 000 $** **Procédure sommaire** • **Emprisonnement minimal de 6 mois pouvant jusqu'à un maximum de 18 mois** • **Amende minimale de 200 $ pouvant aller jusqu'à un maximum de 1 000 $** **(Déportation des immigrants – Fouet)**	*Procédure criminelle* **Droit d'appel** ▪ **Retrait de l'interdiction de porter en appel un verdict de culpabilité et / ou une sentence dans le cas d'une déclaration de culpabilité par procédure sommaire pour l'infraction suivante :** ▪ **obtention de drogues auprès de deux médecins**
	Possession **Aucune modification** *Commerce légal de stupéfiants* **Aucune modification**		

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
1946 – **Modifications à la Loi de 1929**	*Trafic* • **Vente, don, <u>administration illégale</u> ou distribution de drogues à un mineur (1921)**	**Aucune modification**	*Procédure criminelle* **Renversement du fardeau de la preuve** • **Ajout de l'infraction relative à la culture du cannabis sativa ou du pavot somnifère sans permis à la procédure adoptée en 1929**

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
1954 – **Modifications à la Loi de 1929**	*Trafic*	*(Abrogation de la peine de travaux forcés)* *(Abrogation des dispositions concernant la déportation des immigrants. Elle furent transférées à la Loi sur l'immigration en 1952, mais s'appliquent toujours aux infractions liées aux drogues)*	*Pouvoirs policiers* **Saisie et confiscation** • **Modification des pouvoirs de saisie et de confiscation afin d'exclure l'équipement nécessaire pour fumer ou préparer d'opium (infractions abrogées)** *Procédure criminelle* **Renversement du fardeau de la preuve** • **Possession en vue de trafic** ▪ **Dans toute poursuite criminelle impliquant la possession en vue de trafic de drogues, le procureur de la Couronne doit prouver que l'accusé était illégalement en possession de la drogue. Sinon, il est acquitté.** ▪ **Dans le cas contraire, l'intimé doit prouver qu'il ne possédait pas cette substance à des fins de trafic. S'il fait cette démonstration, il est condamné pour simple possession. Sinon, il est condamné pour trafic.**
	• **Importation, exportation, fabrication, vente, administration, transport, livraison et distribution d'une drogue ou d'une substance dont le propriétaire prétend faussement qu'il s'agit d'un stupéfiant**	**Mise en accusation** • **Emprisonnement maximal de 14 ans** • **Fouet (à la discrétion du juge)**	
	• **Possession en vue de trafic**	**Mise en accusation** • **Emprisonnement maximal de 14 ans** • **Fouet (à la discrétion du juge)**	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	• **Culture du pavot somnifère ou du cannabis sativa sans permis**	**Aucune modification**	
	(Abrogation de l'infraction de vente, don ou d'administration d'une drogue à un mineur)		
	(Abrogation de l'infraction de trafic de drogues par courrier)		
	Possession		
	Simple possession	**Mise en accusation** • **Emprisonnement minimal de 6 mois jusqu'à un maximum de 7 ans** **Procédure sommaire** • **Emprisonnement minimal de 6 mois jusqu'à un maximum de 18 mois** **(Fouet (à la discrétion du juge))** ***(Le tribunal ne peut imposer une peine moindre que le minimum prescrit par la Loi)***	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	(Abrogation de l'infraction rendant illégal le fait de posséder de l'opium préparé pour fumeurs ou l'usage d'une telle substance)		
	(Abrogation de l'infraction rendant illégal le fait de se trouver dans un lieu où l'on fume de l'opium)		
	(Abrogation de l'infraction rendant illégale la possession de pipes, lampes ou tout autre équipement ainsi que des différentes pièces de ceux-ci utilisés pour la préparation ou la consommation d'opium)		
	Commerce légal de stupéfiants		
	• **Aucune modification**		

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
1961 – **Loi sur les stupéfiants**	*Trafic* • **Activités illégales définies dans la Loi de 1954 à l'exception des infractions d'importation et d'exportation**	*(Abrogation de la peine de fouet)* **Mise en accusation** • **Emprisonnement maximal de 25 ans (à vie)**	*Pouvoir policiers* **Mandat de main-forte** • **Maintien de cette disposition sans modification**
	• **Tout comme dans le cas des lois antérieures, cette infraction s'étend également aux substances qui sont faussement présentées par un trafiquant comme étant des drogues inscrites à l'annexe**		**Perquisitions** • **Maintien des dispositions autorisant les fouilles et perquisitions <u>sans mandat</u> dans tout lieu ainsi que des personnes s'y trouvant (à l'exception d'une maison d'habitation) où les policiers ont des motifs raisonnables de croire à la présence de drogues ou d'équipements servant à leur fabrication ou consommation**
	• **Exportation et importation**	**Mise en accusation** • **Emprisonnement minimal de 7 ans jusqu'à un maximum de 25 ans (à vie)**	• **Maintien de la disposition autorisant l'usage de la force, si nécessaire, afin de réaliser une fouille ou perquisition <u>en précisant qu'un policier peut forcer une porte ou une serrure, enfoncer un mur et un plafond, ou briser les objets susceptibles de contenir des drogues</u>**
	• **Possession en vue de trafic**	**Mise en accusation** • **Emprisonnement maximal de 25 ans (à vie)**	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	• **Culture du pavot somnifère ou du cannabis sativa sans permis**	**Mise en accusation** • **Emprisonnement maximal de 7 ans**	• **Maintien de la procédure prévoyant qu'un policier peut obtenir l'assistance d'une personne qu'il désigne pour mener à bien une perquisition**
	Possession **Simple possession**	**Mise en accusation** • **Emprisonnement maximal de 7 ans**	*Procédure criminelle* **Renversement du fardeau de la preuve** • **Maintien de la procédure adoptée en 1954 dans le cas d'une infraction de possession en vue de trafic avec quelques modifications pour clarifier la procédure et garantir un plus grand respect du principe de présomption d'innocence.**
	Commerce légal de stupéfiants • **Transfert des dispositions législatives adoptées entre 1911 et 1946 concernant le commerce légal de stupéfiants de la Loi aux règlements** • **Règlements adoptés par le gouverneur en conseil concernant les activités légitimes des entreprises, médecins et pharmaciens en matière de vente, production, distribution, administration, prescriptions et tenue de registres**	**Procédure sommaire** • **Emprisonnement maximal de 6 mois; et / ou** • **Amende maximale 500 $**	• **Maintien de la procédure prévoyant qu'un accusé doit prouver qu'il a agi légitimement pour des fins thérapeutiques ou scientifiques grâce à une autorisation gouvernementale** **Certificat d'un analyste fédéral ou provincial** • **Maintien de cette disposition tout en précisant que l'analyste serait nommé en fonction de la *Loi sur les aliments et les drogues*.**

Détention préventive

- **Pour une infraction de trafic, de possession en vue de trafic, ou d'exportation ou importation de drogues, le tribunal peut ordonner que l'accusé soit placé en détention préventive pour une période indéterminée. Cette mesure remplace toute autre sentence qui pourrait lui être imposée.**

(Cette disposition n'a jamais été proclamée)

Traitement

- **Dans le cas d'infractions de simple possession, de trafic, de possession en vue de trafic, ou d'exportation ou d'importation, le tribunal, sur demande du procureur de la Couronne ou de l'accusé, peut renvoyer ce dernier en détention pour examen afin de déterminer s'il est admissible à un programme de traitement pour toxicomanie.**

Confiscation

- **Maintien du pouvoir de confisquer au profit du ministre de la Santé et du Bien-être les drogues, seringues, aguilles, équipements ainsi que l'argent utilisé pour l'usage, la fabrication ou l'achat de telles substances suivant une infraction de simple possession, de trafic, de possession en vue de trafic, ou d'exportation ou d'importation *(Le ministre peut disposer de ces substances selon les dispositions prévues par les textes réglementaires)***

- **Maintien du pouvoir de confisquer tout véhicule moteur, aéronef, navire ou autre moyen de transport utilisé pour faire le trafic, l'exportation ou l'importation de drogues**

Restitution

- **Maintien du régime prévoyant une ordonnance de restitution des drogues ou objets liés à leur fabrication ou leur usage préalablement à leur confiscation au profit du ministre de la Santé et du Bien-être**

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	• Si tel est le cas, l'accusé doit être condamné à la détention aux fins de traitement dans une institution fédérale spécialisée pour une période indéterminée au lieu de toute autre sentence prévue par la Loi. • Dans le cas d'une première infraction, la détention préventive ne peut excéder 10 ans. • L'intimé dispose d'un droit d'appel, est assujetti à la *Loi sur les libérations conditionnelles* et, à tout moment, peut être renvoyer en détention préventive s'il fait usage de drogues au cours de sa période de probation		Toutefois, certains critères s'appliquent avant qu'un tribunal ordonne la restitution : • La demande doit être faite au tribunal au plus tard deux mois après la saisie; • S'il est convaincu que le demandeur n'est pas impliqué dans l'infraction, le tribunal doit restituer immédiatement les drogues ou objets saisis s'il est convaincu qu'ils ne seront pas nécessaires à la poursuite d'une enquête ou des procédures judiciaires • Par contre, si le tribunal en décide autrement, ils ne seront restitués qu'à la fin du procès ou après l'expiration d'un délai de quatre mois si aucune poursuite n'est entamée contre l'accusé Le demandeur dispose d'un droit d'appel

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	• Si une province adopte une politique de détention préventive accompagnée d'un programme de traitement pour toxicomanie (dans les cas qui n'impliquent pas une infraction à la Loi), le gouvernement fédéral peut conclure une entente avec les autorités provinciales compétentes afin de transférer les toxicomanes dans les institutions fédérales spécialisées. (Ces dispositions n'ont jamais été proclamées)		**Demande de tiers intéressés** • Création d'un régime autorisant un tiers intéressé – une personne qui n'a pas été impliqué dans l'infraction – à faire une demande d'ordonnance au tribunal pour la restitution d'un aéronef, d'un véhicule moteur, d'un navire ou de tout autre moyen de transport. Les procédures qui s'appliquent pour la délivrance d'une telle ordonnance sont semblables à celles susmentionnées pour la restitution d'objets saisis lors d'une opération policière. Le tiers dispose également d'un droit d'appel **Droit d'appel** • Abrogation de l'interdiction d'en appeler d'un verdict de culpabilité ou d'une sentence pour certaines infractions

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
			Empreintes digitales et casier judiciaire • **Abrogation de la procédure prévoyant l'application des dispositions de la *Loi sur l'identification des criminels* aux personnes condamnées par procédure sommaire (1923)**

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
1961 – **Loi sur les aliments et drogues**	*Ajout de la partie III à la Loi sur les aliments et drogues – Barbituriques et amphétamines* **(Drogues contrôlées – Annexe G)** *Trafic*		*Pouvoirs policiers* • **Pouvoirs policiers semblables à ceux prévus par la *Loi sur les stupéfiants* de 1961 qui, toutefois, ne s'appliquent pas à la simple possession de drogues contrôlées**
	• **Fabrication, vente, transport, exportation, importation ou livraison d'une drogue contrôlée sans autorisation des autorités fédérales** *(Exclusion de l'administration ou de la distribution de telles substances)*	**Mise en accusation** • **Emprisonnement maximal de 10 ans** **Procédure sommaire** • **Emprisonnement maximal de 18 mois**	*Procédure criminelle* • **Procédures criminelles semblables à celles prévues par la *Loi sur les stupéfiants* de 1961 qui, toutefois, ne s'appliquent pas à la possession de drogues contrôlées**
	Possession en vue du trafic • **Possession en vue de trafic**	**Mise en accusation** • **Emprisonnement maximal de 10 ans** **Procédure sommaire** • **Emprisonnement maximal de 18 mois**	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	Possession • <u>**Aucune infraction pour simple possession**</u>		
	Commerce légal des drogues contrôlées • **Règlements adoptés par le gouverneur en conseil concernant les activités**	**Procédure sommaire** • **Emprisonnement maximal de 6 mois; et / ou** • **Amende maximale 500 $**	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
1969 – **Loi sur les aliments et drogues**	*Ajout de la partie IV à la Loi sur les aliments et drogues – Hallucinogènes* (Drogues à usage restreint – Annexe J)		*Pouvoirs policiers* • Pouvoirs policiers semblables à ceux prévus à la Partie III. Contrairement à cette dernière, ils s'appliquent également à la simple possession de drogues à usage restreint
	Trafic • Fabrication, vente, transport, exportation, importation ou livraison d'une drogue d'usage restreint sans autorisation des autorités fédérales *(Exclusion de l'administration ou de la distribution de telles substances)*	Mise en accusation • Emprisonnement maximal de 10 ans Procédure sommaire • Emprisonnement maximal de 18 mois	*Procédure criminelle* • Procédures pénales semblables à celles prévues par la Partie III. Contrairement à cette dernière, elles s'appliquent également à la simple possession de drogues à usage restreint Certificat de l'analyste nommé conformément à la *Loi sur les aliments et drogues*
	Possession en vue de trafic • Possession en vue de trafic	Mise en accusation • Emprisonnement maximal de 10 ans Procédure sommaire • Emprisonnement maximal de 18 mois	• Modification à la procédure d'admissibilité du certificat de l'analyste lors d'un procès En vertu de la Loi de 1961, un tribunal pouvait admettre en preuve le certificat de l'analyste nommé en fonction de la *Loi sur les aliments et drogues*. Ce document constituait une preuve *prima facie* et péremptoire du statut de la personne qui le donne

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	Possession • Simple possession	Mise en accusation • Emprisonnement maximal de 3 ans; ou • Amende de 5 000 $ Procédure sommaire *Première infraction* • Emprisonnement maximal de 6 mois; et / ou • Amende maximale de 1 000 $ *Infractions subséquentes* • Emprisonnement maximal d'un an; et / ou • Amende maximale de 2 000 $	ou l'émet. Dans ce contexte, il n'était ni nécessaire de prouver la nomination de cette personne ni de procéder à l'authentification de sa signature. En 1969, cette procédure a été modifiée afin de permettre au procureur de la Couronne de prouver oralement sous serment, par affidavit ou par déclaration solennelle le statut de la personne qui a signé le certificat. Ainsi, elle n'a pas à se présenter devant le tribunal. Toutefois, un juge peut exiger que l'analyste se présente devant lui afin d'être interrogé ou contre-interrogé pour mieux évaluer les renseignements inscrits dans l'affidavit ou la déclaration solennelle.

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
	Commerce légal des drogues d'usage restreint		
	• **Règlements adoptés par le gouverneur en conseil**	**Procédure sommaire** • **Emprisonnement maximal de 18 mois; et / ou** • **Amende de 500 $**	

Lois	Infractions	Peines	Pouvoirs policiers – Procédure criminelle
1969 – **Modifications à la Loi sur les stupéfiants**	*Simple possession*	**Mise en accusation** • **Emprisonnement maximal de 7 ans** **Procédure sommaire** *Première infraction* • **Emprisonnement maximal de 6 mois; et / ou** • **Amende maximale de 1 000 $** *Infractions subséquentes* • **Emprisonnement maximal d'un an; et / ou** • **Amende maximale de 2 000 $**	*Procédure criminelle* **Certificat de l'analyste** • **Modifications identiques à celles apportées à la** ***Loi sur les aliments et drogues***

Act	Offences	Penalties	Police Powers – Criminal Procedure
Act of 1988 – Amendments to Act of 1961	*Trafficking* Exporting and importing	Indictment • Imprisonment for a term not exceeding 25 years (life) *(In 1987, the Supreme Court of Canada ruled in R. v. Smith that it was unconstitutional to impose a sentence of imprisonment for a term of not less than 7 years)*	*Police powers* The *Criminal Code* provisions concerning search, seizure and detention powers relating to the offences of possession of property obtained through drug trafficking and laundering the proceeds of crime also apply to the *Narcotic Control Act*
	• Possessions of property obtained through drug trafficking *(This new offence applies to the illegal activities of cultivating, trafficking in, exporting and importing drugs in Canada or in a foreign country where those offences are committed by Canadian citizens)*	(Value of more than $1,000) Indictment • Imprisonment for a term not exceeding 10 years • (Value of less of than $1,000) Indictment • Imprisonment for a term not exceeding 2 years	*Criminal procedure* The *Criminal Code* provisions concerning forfeiture and restoration, third party applications and the management of property seized in relation to the offences of possession of property obtained through drug trafficking and laundering the proceeds of crime also apply to the *Narcotic Control Act*

Act	Offences	Penalties	Police Powers – Criminal Procedure
		Summary conviction • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $2,000**	
	• **Laundering the proceeds of crime** *(This new offence applies to the illegal activities of cultivating, trafficking in, exporting and importing drugs in Canada or in a foreign country where those offences are committed by Canadian citizens)*	**Indictment** • **Imprisonment for a term not exceeding 10 years** **Summary conviction** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $2,000**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1996 – **Controlled Drugs and Substances Act**	Schedule I: Opiates (opium, morphine, heroin, codeine, cocaine, morphinans, etc.) Schedule II: Cannabis (marijuana), hashish, cannabinol, etc. Schedule III: Amphetamines and hallucinogenics (mescaline, LSD, DET, PCP) Schedule IV: Barbiturates, benzodiazepines (Seconal, Luminal, Valium and Librium) and anabolic steroids Schedule V: Other substances giving rise to abuse Schedule VI: Precursors (simili-drugs and designer drugs) Schedule VII: Cannabis trafficking • Under 3 kg of cannabis (marijuana) or hashish Schedule VIII: Cannabis possession Under: • 1 gram of hashish; or • 30 grams of cannabis		*Police powers* Search and seizure • Repeal of the right to conduct searches and seizures without a warrant • Search or seizure <u>without a warrant</u> allowed in exigent circumstancts • Continuation of procedures for the seizure of a means of transportation, an object or a designated substance with the use of force, if necessary, or assistance of persons other than police officers However, following a search or seizure with or without a warrant, police officers are required to send a report to the justice of the peace and to the Minister of Health stating: ▪ the place of the search; ▪ the designated substance; and ▪ the place where that substance was stored

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Trafficking or possession for the purpose of trafficking • Administration, gift, transportation, dispatch, and delivery of a designated substance, or any other activity outside the regulatory framework *(Designated substance includes: natural and synthetic drugs, any other substance the owner of which falsely claims is a drug and objects used to use, make or store a drug)*		• Extension of powers of search already provided for by the *Narcotic Control Act* to: ▪ real property and those modified for criminal purposes (premises of criminal organizations); and ▪ where police officers have reasonable grounds, to any other object which might establish evidence of an offence
	Schedules I and II	Indictment • Imprisonment for a term not exceeding 25 years (life)	• Validity of a search warrant in a province other than the one where it was given Policy immunity
	Schedule III	Indictment • Imprisonment for a term not exceeding 10 years Summary conviction • Imprisonment for a term not exceeding 18 months	• In 1996, the *Controlled Drugs and Substances Act* allowed the Governor in Council to authorize by regulations police officers to possess and traffic in designated substances sting operations *(Currently, sections 4, 5, 6, 7, 8 and 9 of the CDSA prohibit possession, possession for the purpose of trafficking, importing, exporting, producing narcotics, possession of*

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Schedule IV	Indictment • Imprisonment for a term not exceeding 3 years Summary conviction • Imprisonment for a term not exceeding one year	*property obtained by criminal activity and laundering of proceeds of crime.* *However, section 3 of the Narcotic Control Regulations authorizes inspectors and police officers to possess drugs for the purposes of or in relation to their duties. This provision existed in the regulations relating to the Narcotic Control Act to prevent a police officer from being charged with possession following a search)*
	Schedule VII	Indictment • Imprisonment for a term not exceeding 5 years less a day	
	• Cultivation or production		*In addition, the police enforcement regulations made under the Controlled Drugs and Substances Act provides for an exemption for peace officers from the application of sections 4, 5, 6, 7 8 and 9 of the Act. In that case, the persons concerned by that provision must at all times be active members of a police force and must be found in the performance of their duties during the investigation in question)*
	Schedules I and II (except cannabis)	Indictment • Imprisonment for a term not exceeding 25 years (life)	
	Cannabis	Indictment • Imprisonment for a term not exceeding 7 years	• In December 2001, the *Criminal Code* was amended (Bill C-24) to grant police officers, on certain conditions, legal immunity when required to commit an indictable

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Schedule III	Indictment • Imprisonment for a term not exceeding 10 years Summary conviction • Imprisonment for a term not exceeding 18 months	offence in the course of an investigation or operation to infiltrate a criminal or terrorist organization. However, they are granted no legal immunity if they commit the following offences: murder, manslaughter, bodily harm, obstructing the administration of justice and sexual assault.
	Schedule IV	Indictment • Imprisonment for a term not exceeding 3 years Summary conviction • Imprisonment for a term not exceeding one year	*Criminal procedure* Sentencing • Definition of guiding principles for sentencing (compliance with the Act, maintaining a just and peaceful society, social reintegration, treatment and reparation of harm caused to victims)
	▪ Exporting and importing Schedules I and II	Indictment • Imprisonment for life (25 years)	• Definition of aggravating circumstances: ▪ use of a weapon;
	Schedules III and VI	Indictment • Imprisonment for a term not exceeding 10 years Summary conviction	▪ resorting to violence; ▪ trafficking in a substance designated under Schedules I, II, III and IV with a minor or on a school ground

Act	Offences	Penalties	Police Powers – Criminal Procedure
		• Imprisonment for a term not exceeding 18 months	▪ prior convictions under the Act; ▪ and use of a minor to commit an offence
	Schedules IV or V	Indictment • Imprisonment for a term not exceeding 3 years Summary conviction • Imprisonment for a term not exceeding one year	• Any court that decides not to impose a sentence of imprisonment in cases involving aggravating circumstances must give reasons for that decision Forfeiture • Continuation of the provision allowing forfeiture of: ▪ designated substances; ▪ means of transportation and property acquired by drug trafficking (expands powers to include ordinary real property or real property modified for criminal purposes); and ▪ proceeds of crime • Continuation of the procedure regarding applications by third parties, stipulating, however, that the application must be made by Crown prosecutor. He must prove that the property is necessary to

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• Possession of property obtained through trafficking in designated substances *(This offence applies to the illegal activities of cultivating, trafficking in, exporting and importing drugs in Canada or in a foreign country where those offences are committed by Canadian citizens)*	(Value of more than $1,000) Indictment • Imprisonment for a term not exceeding 10 years (Value of less of than $1,000) Indictment • Imprisonment for a term not exceeding 2 years Summary conviction • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $2,000	that the property is necessary to the investigation and prosecution. Otherwise, property is automatically returned to the owner • Creation of a restraint order in respect of offence-related property, real property and proceeds of crime • Creation of a separate procedure for restoring or disposing of designated substances in order to clarify the provisions of the *Narcotic Control Act* in this respect • Possibility that property or proceeds of crime may be forfeited to the Minister of Public Works and Government Services Canada or the <u>Solicitor General of a province.</u>
	• Laundering of the proceeds of crime *(This n offence applies to the illegal activities of cultivating, trafficking in, exporting and importing drugs in Canada or in a foreign country where those offences are committed by Canadian citizens and is more particularly aimed at money laundering)*	Indictment • Imprisonment for a term not exceeding 10 years Summary conviction • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $2,000	Federal inspectors • Definition of the powers of inspectors appointed by the federal government to enforce regulations governing legal trade of designated substances. Inspectors may:

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Possession • Possession Schedule I	Indictment • Imprisonment for a term not exceeding 7 years Summary conviction • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000	▪ enter (with the consent of one of the occupants), examine and search, without a warrant any place, equipment or receptacle used to produce or store a designated substance or precursor; ▪ search any dwelling house, with a warrant used to produce or store a designated substance or precursor;
	Schedule II	Indictment • Imprisonment for a term not exceeding 5 years less a day Summary conviction (First offence) • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000	▪ take away any computer hardware used to store information on designated substances or precursors; ▪ seize such substances if necessary and return them in accordance with the regulations; and ▪ use force or be accompanied by a police officer to execute their warrant Arbitration and designated regulations • Creation of a special procedure - the Governor in Council may designate regulations – known as "designated regulations" – the

Act	Offences	Penalties	Police Powers – Criminal Procedure
		(Subsequent offences) • Imprisonment for a term not exceeding one year; and / or • Fine not exceeding $2,000	contravention of which is dealt with under special administrative orders • Creates an arbitration mechanism enabling pharmacists, physicians and businesses to dispute orders made under designated regulations by the Department of Health and following an investigation by an investigator into offences under the designated regulations
	Schedule VIII	Summary conviction • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000	
	Schedule III	Indictment • Imprisonment for a term not exceeding 3 years Summary conviction (First offence) • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000	

Act	Offences	Penalties	Police Powers – Criminal Procedure
		(Subsequent offences) • Imprisonment for a term not exceeding one year; and / or • Fine not exceeding of $2,000	
	• Disclosure of previous prescriptions to a physician (1985)		
	Schedule I	Indictment • Imprisonment for a term not exceeding 7 years Summary conviction (First offence) • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000 (Subsequent offences) • Imprisonment for a term not exceeding one year; and / or • Fine not exceeding $2,000	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Schedule II	**Indictment** • Imprisonment for a term not exceeding 5 years less a day **Summary conviction** **(First offence)** • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000 **(Subsequent offences)** • Imprisonment for a term not exceeding one year; and / or • Fine not exceeding $2,000	
	Schedule III	**Indictment** • Imprisonment for a term not exceeding 3 years	

Act	Offences	Penalties	Police Powers – Criminal Procedure
		Summary conviction **(First offence)** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $1,000** **(Subsequent offences)** • **Imprisonment for a term not exceeding one year; and / or** • **Fine not exceeding $2,000**	
	Schedule IV	**Indictment** • **Imprisonment for a term not exceeding 18 months** **Summary conviction** **(First offence)** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $1,000**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
		(Subsequent offences) • Imprisonment for a term not exceeding one year; and / or • Fine not exceeding $2,000	
	Legal trade in narcotic drugs • Regulations made by the Governor in Council	Indictment • Imprisonment for a term not exceeding 3 years; and / or • Fine not exceeding $5,000 Summary conviction • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000	
	Therapeutic use of cannabis • Authorization to use this designated substance for therapeutic or scientific purposes Under section 56 of the Act, the Minister of Health may on such terms and conditions as he may		

Act	Offences	Penalties	Police Powers – Criminal Procedure
	set, exempt from the application of all or any part of the Act any person or class of persons or any designated substance referred to in a schedule to the Act In July 2000, this procedure was ruled unconstitutional by the Ontario Court of Appeal in *R. v. Parker*. At the time, the court held that the minister's power to grant an exemption to allow the use of marijuana or other drugs for therapeutic purposes was too broad and contrary to section 7 of the *Canadian Charter of Rights and Freedoms* (liberty and security of the person, fundamental justice) To correct the situation, the federal government made regulations in July 2001 allowing the therapeutic use of cannabis *Preventive detention (1961)* • Provision repealed *Detention for treatment (1961)* • Provision repealed		